

**THE EFFECTS OF HIV/AIDS-RELATED  
MORTALITY ON FAMILY STRUCTURES IN  
NAMIBIA:  
*SELECTED CASE STUDIES FROM NAMIBIAN AIDS  
SERVICE ORGANISATIONS***

**Thesis submitted by Lucy Edwards-Jauch**

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**Supervisors:**

**Dr. V. Winterfeldt (Sociology Department, University of Namibia)**

**Prof. P. Mufune (Sociology Department, University of Namibia)**

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## **Abstract**

This research dissertation was undertaken to increase knowledge of the effects of AIDS related adult mortality on family structures in Namibia. Previous research focused mainly on very specific effects like food security or the needs of OVCs. This research includes changes in family size, form, composition, economic activities and distribution of the care burden as a result of AIDS related adult morbidity and mortality.

The researcher combined a critical approach towards the literature with a qualitative, ethnographic approach to the empirical study. The rural fieldwork was done in villages around Eehana, Okongo and Engela in the Ohangwena Region of Namibia. Fieldwork in the urban area was done in Katutura, Windhoek. The target population consisted of HIV and AIDS affected families. Access to these families was facilitated by NGOs that provide services to them. Semi-structured interviews (SSIs), Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs) were the primary tools of empirical data collection.

The key findings were that AIDS mortality intersects with other social factors to bring about changes in family structures. Mortality influences the composition of the families as it depletes the middle layer; therefore the most frequently occurring family form was the matrifocal family, headed by an elderly female with a number of younger dependents who could be grandchildren, great grandchildren, the children of the departed husband's co-wives or of other members of the kinship group. As a result of migration and mortality, family and household boundaries do not always intersect. This gives rise to split

households within the family. Household boundaries are often porous with constant inward and outward migration due to high levels of mortality and out of wedlock birth rates. Adult mortality results in income and productivity losses which in turn give rise to food insecurity, starvation and a lack of access to services. Despite these hardships the majority of OVCs in affected families are able to stay in school and to benefit from care and support within the extended family network. The findings do not support theories of family decline, but rather that AIDS mortality brings about changes in family form, size, composition and economic reproduction.

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**Everybody's child** by **Anicia Peters**

I remember when Anybody's child could walk the streets,  
free from fear and protected by Everybody.  
Anybody's child who dared to do some wrong  
would be reprimanded, even hit, by Anybody.  
Anybody's child who dared to roam the streets after dark  
would be taken or chased home by Anybody.  
Anybody's child who was hungry was fed by Anybody.  
Anybody's child who got hurt was comforted by Anybody.  
Anybody's child who was in danger was protected by Anybody.  
Because Anybody's child was Everybody's child.

Now, Anybody's child cannot be reprimanded  
because it is Somebody's child.  
Anybody's child cannot be rescued, because it is Somebody's child.  
Anybody's child cannot be fed because it is Somebody's child.  
Anybody's child cannot be protected because it is Somebody's child.  
And Somebody has to take the blame for Everybody's child.

Nobody sees Somebody's child wandering alone.  
Nobody sees the hunger in Somebody's child.  
Nobody hears Somebody's child scream.  
Somebody's child gets raped and killed.  
Now everybody asks, where was somebody?

What happened to Everbody's child?

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## List of Abbreviations and Acronyms

ABC	Abstinence, Be Faithful and Condom Use
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
ASO(s)	AIDS Service Organisation(s)
BIG	Basic Income Grant
CAA	Catholic AIDS Action
CADRE	Centre for AIDS Development, Research and Evaluation
CAFO	Church Alliance for Orphans
CBO(s)	Community-Based Organisation(s)
CBS	Central Bureau of Statistics
CDC	Centre for Disease Control
CDC(s)	Children in Difficult Circumstances
CD4	Count Cluster of Differentiation 4
CHH	Child Headed Household
CHS	Community Household Surveillance Survey
CIIR	Catholic Institute for International Relations
CNN	Condom use, needles (clean needles) and negotiating skills
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Survey
EHH	Elderly Headed Household
FAO	Food and Agricultural Organization
FBO(s)	Faith Based Organisations

FGD(s)	Focus Group Discussions
FHH	Female Headed Household
GDP	Gross Domestic Product
Global Fund	Global Fund to fight AIDS, Tuberculosis and Malaria
GRN	Government of the Republic of Namibia
HAART	Highly Active Antiretroviral Therapy
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
IBIS	Danish NGO (WUS Denmark)
HRA	Human Rights Approach
ILO	International Labour Organization
IMF	International Monetary Fund
KII(s)	Key Informant Interview/s
KWID	Khomas Women in Development
LAC	Legal Assistance Centre
LE	Lironga Eparu
MBESC	Ministry of Basic Education Sport and Culture
MGECSW	Ministry of Gender Equality and Child Welfare
MOE	Ministry of Education
MoHSS	Ministry of Health and Social Services
MoLSW	Ministry of Labour and Social Welfare
MRLGH	Ministry of Regional and Local Government, Housing and Rural Development
MSM	Men having Sex with Men
MTP	Medium Term Plan



MTCT	Mother-To-Child Transmission
MWACW	Ministry of Women's Affairs and Child Welfare (now the MGECW)
MYNSSC	Ministry of Youth, National Service, Sport and Culture
NAC	National AIDS Committee
NCAS	Namibia Child Activities Survey
NACP	National AIDS Control Programme
NACOP	National AIDS Coordination Programme
NAMACOC	National Multi-Sectoral AIDS Coordinating Committee
NANASO	Namibia Network of AIDS Services
Nampa	Namibia Press Agency
NEPAD	New Partnership for Africa's Development
NEPRU	Namibia Economic Policy Research Unit
NDP	National Development Plan
NGO(s)	Non Governmental Organisations
NPC	National Planning Commission
NHIES	Namibia Household Income and Expenditure Survey
NRCS	Namibia Red Cross Society
NSHR	National Society for Human Rights
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLWA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-To-Child Transmission
PTF	Permanent Task Force
RACOC	Regional AIDS Coordinating Committee

SafAIDS	Southern Africa HIV/AIDS Information Dissemination Service
SIAPAC	Social Impact Assessment and Policy Analysis Corporation (Pty) Ltd.
SARDC	Southern African Research and Documentation Centre
SSI(s)	Semi-structured Interviews
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
TB	Tuberculosis
TRIPS	Trade Related Intellectual Property Rights
trp	The Rainbow Project
UN	United Nations
UNFPA	United Nations Population Fund
UNGASS	UN General Assembly Special Session on HIV/AIDS
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNAM	University of Namibia
UNICEF	United Nation's Children's Fund
USAID	United States Agency for International Development
VTC	Voluntary Testing and Counselling
WFCL	Worst Forms of Child Labour
WFP	World Food Programme
WHO	World Health Organisation
WIMSA	Working Group of Indigenous Minorities of Southern Africa

# Chapter 1: Introduction

## 1.1 Introduction

Throughout human history family forms have altered as a result of major social, economic and demographic changes. In some Namibian ethnic cultures polygamous and extended families have been the most basic units of production and reproduction. Colonialism, Christianity, wage labour, migration and the National Liberation Struggle have all in some way or another influenced family form. Today various family forms co-exist be they matrifocal, nuclear, monogamous, neolocal, polygamous, extended, patrilocal, reconstituted or blended families.

Some argue that family form is a function of the economic mode of production and that the dominant mode of production produces an ideal family type. Namibian society is in transition and is characterised by fragmentation, dualisms and the articulation of different modes of production.<sup>i</sup> This confluence creates diversity in social forms and institutions. Therefore diverse family forms co-exist. These diverse family forms are further mediated by other factors like gender, race, ethnicity and social class.

AIDS is changing the demographic structure of sub-Saharan African countries. It is a leading cause of death. (UNAIDS: 2004) In addition demographers predict reductions in fertility rates, reduced life expectancy and changes in the age structure of the population. Some estimate that the neontic (green) dependency ratio will decrease because of decreased fecundity due to illness and the increased use of condoms and other safe-sex technologies. (Zeihl: 2002) Namibia however, is still faced with high neontic dependency ratios as the result of the post independence baby boom. Empirical findings show an increase in orphans as a result of AIDS mortality. (UNICEF: 2005 a)

Many orphans are absorbed into extended family structures. This could be due to the fact that the extended family traditionally constituted the social security net, and this phenomenon intensifies when there is an absence of adequate, state sponsored, social security programmes. The extended family is, however, not always a haven of love and support. Tradition places pressure on families to take on the care burden, which is sometimes taken on with reluctance. This can result in resentment, stigmatisation and discrimination towards PLWA and OVCs. (Ntozi: 1997 and Ruiz-Casares: 2005)

Changes in the demographic structure lead to changes in families and households. Adult morbidity and mortality result in the depletion of a middle layer of society since most AIDS-related deaths occur amongst people in the 19-49 year age group. (Republic of Namibia: 2006) Adult mortality has an effect on the family's survival and life chances. It threatens household food security and results in productivity and income losses as well as increased expenditure. These effects are most acute in the subsistence farming areas where labour intensive crop production is the main source of livelihood. Different survival strategies are employed to mitigate the effects of mortality, for example the blending of households, the substitution of adult with child labour, decreases in the amount of land under cultivation, crop switching from more nutritious, labour-intensive crops to less nutritious ones to offset labour shortages, and the sale of productive assets for immediate survival. (De Waal, 2003; Barnett and Whiteside, 2002& 2006; Von Liere 2002)

Fostering of children inside the extended family has historically been a common feature of African society. However, AIDS mortality has forced an interrogation of romantic notions of the extended family. While research shows that the extended family often assumes responsibility for the care of orphans, these care arrangements are not always ideal. In most cases OVCs are taken into

female-headed or elderly-headed households with a low resource base to begin with. Non-relative foster care and institutional care arrangements are still frowned upon and have so far received secondary status in policy frameworks. The “disinheritance” of widows and children raises a spectre of doubt and begs the question whether the supportive extended family is in fact myth or reality. While parts of African culture like systems of reciprocity and collective childcare are beneficial, African culture is also embedded in deep rooted patriarchy. This is often oppressive towards women, children and homosexuals.

## **1.2 Statement of the Problem**

There is a lack of sociological studies on family forms in Namibia. This research is a direct response to that knowledge gap, and only concentrates on the relationship between HIV/AIDS-related mortality and family structures. In particular it observes changes in family composition, size, functions, family life cycles, intergenerational processes, residential patterns, access to resources and economic organisation as a result of AIDS related adult mortality.

## **1.3 Scope of the Study**

The research looks at the changes in family structures in an urban and a rural area. Most of the empirical data collection was therefore done in the rural villages in the Ohangwena Region, specifically villages around Eenhana, Okongo and Engela. In the urban area data collection occurred in Katutura, a township in the capital, Windhoek. The stratification areas were largely determined by the operational areas and client bases of two AIDS Service Organisations, namely the Namibia Red Cross Society (NRCS) and Khomas Women in Development (KWID). These two organisations helped to identify AIDS-affected families since they provide services to such families. The study focuses on the changes

in families, and therefore does not look at other care agencies like orphanages. Nor does it look at the plight of children who were not absorbed into family structures and who have been abandoned to become street children.

## **1.4 Research Questions**

### **Key Research Question**

What are the effects of AIDS related adult mortality on families?

### **Sub questions**

- Which family forms are affected by AIDS mortality?
- What strategies are adopted to care for orphaned and vulnerable children (OVCs)?
- What are the needs of OVCs?
- Who are the primary caregivers of paternal, maternal and double orphans?
- How did AIDS mortality change family form, size, composition, and functions?
- How does AIDS mortality affect extended family networks?
- How does AIDS mortality intersect with race, ethnicity, gender and social class?
- What kinds of inter-generational processes take place in the affected families?
- How do affected families deal with questions of descent and inheritance?
- Do changes in family composition affect family cycles?
- Does AIDS mortality bring about changes in the division of labour within families?

## **1.5 Objectives of the Study**

- a) To document the experiences of families affected by AIDS mortality
- b) To explore the relationship between AIDS-related orphanhood and family structures

c) To capture the changes in family structures as a result of AIDS-related adult mortality

## 1.6 Significance of the Study

Namibian Sociology is in its infancy, and many societal processes are not yet available for scholarship simply because they have not been researched and recorded. There is a need to enhance Namibian scholarship by subjecting Namibian social institutions like families to scrutiny. There is also a need to record the social and historical development of these institutions to make it accessible to future generations of scholarship. Therefore, a study on the impact of AIDS mortality on family forms will make a contribution towards the body of academic knowledge in the field and could contribute towards policy discourse.

## 1.7 Clarification of key concepts

A number of concepts are used in this research and in this section these concepts are briefly clarified to explain what the author understands by these concepts and how they are used in the context of this research.

**Affinal kin:** When family ties and alliances are forged between kinship groups as a result of marriage between members of different family groups.

**African Family:** The validity of the term African family as a conceptual category has been questioned, and it became necessary to distinguish African family forms from others. In broad economic terms Africa did follow an economic trajectory from foraging to domestication as was the case in Europe. This however cannot lead to the conclusion that its social and cultural institutions followed the same pattern. Marx tried to impose universal categories and stages on the historical and material development of human societies, but Africa has remained difficult to classify, and the universal modes of production

debate still rages on within African studies. (Austen, 1987) From most accounts of African history, the continent did not go through the feudal mode of production with a landholding aristocracy that could command the labour of a peasantry. Land as a key productive resource was never privately owned until the imposition of capitalism. Even forms of moveable property, like cattle, would at times be corporately owned i.e. belonging to the family group. This meant that a male heir of cattle could not dispose of this resource without consulting the family group. Traditionally, in some cultures, the male heir simply held cattle in trust for the family group. The familial subsistence economy was more gender-based than class-based because of the lack of private property. Social class development, an important determinant of family form, was therefore not the same as in Europe. There are also important physical, economic, cultural and political markers that distinguish Africa from other continents. Despite the diversity in Africa, there is a common history that links western, eastern and southern Africa. It is generally accepted (Parsons, 1982; Hall, 1986; Austen, 1987) that the Bantu speaking groups that now cover most of sub-Saharan Africa have a common ancestry in West Africa and migrated from there during the early and late Iron Age. This is supported by linguistic evidence, livestock communalities, genetic and physical characteristics, millet cultivation and metallurgy. One common economic feature was the mafisa or cattle system, which is a tributary system of cattle lending. This formed a source of power to local chiefs and an important element in social stratification. With regard to family and kinship structures there were also similarities like male polygamy, lobola payment and male and female initiation. (Parsons, 1982)

**Conjugal Family:** Families that are constituted through marriage and normally consist of one or more husbands and one or more wives and their dependent children.

**Consanguine families:** Families that are constituted by people who share blood ties and who trace group membership to biological or genealogical connections.

**Double Orphans:** Children who have lost both parents



**Dyad:** A type of relationship between members of the family group. Maternal dyad is between mother and child, the paternal dyad between father and child, and sibling dyads are formed between brothers and/or sisters.

**Extended family:** Larger than the nuclear family, which can be extended vertically when additions occur across generations (inter-generational), or horizontally when additions occur within the same generation (intra-generational)

**Family:** Family identity has traditionally been based on kinship, and kinship is still the key marker of family identity. There are diverse family forms that could consist of varying combinations of people who are related by blood or marriage. There are also families that exist as a result of blending, adoption and surrogacy, where there are no blood ties.

**Family form:** Traditional family sociology assumes that “the family” is a universal institution that has changed in size and composition, and functions with the development of industrial capitalism. Increasingly this ethnocentric universality thesis is questioned. In Namibia there are diverse family forms that have been shaped by multiple social and cultural factors. The term “family form” rather than “the family” is used to capture this diversity.

**Familial Households:** This is an indication that the family and household boundaries converge, and that the household consists of a family group, irrespective of how it is constituted.

**Fictive families:** Where there are no genealogical, conjugal or affinal relations and other socio-cultural criteria are used to establish familial connections, for example namesakes.

**Household:** Households are task-orientated residential units that co-operate economically. In the majority of cases households also consist of families, or families make up the core membership of a household. There are cases where households consist of unrelated kin (e.g. student communes) or where through migration families are split between different households. Sociology has been criticised for trying to draw distinctions between households and families without taking into account the diversity

and fluidity brought about by diverse cultural and socio-economic conditions. Households often refer to people who share a physical space or address but are not necessarily bound by kinship ties. In trying to delineate the family - household divide, one has to take into account:

- a) The subjective and self identification of domestic forms by those involved in a particular spatial, social and economic organisation of domestic life.
- a. In some instances the diverse spatial, kinship and resource sharing arrangements may blur boundaries between family and household, and therefore make it difficult to distinguish between the two.

**HIV and AIDS:** In the earlier literature no distinction is made between HIV and AIDS until it was decided that a clear distinction should be drawn between HIV (indicating infection by a virus) and AIDS (the illness) since many HIV positive persons do not necessarily have AIDS. This has been the trend since 2006. In this study the author sometimes draws the distinction and at times uses the collective concept HIV/AIDS to show the relatedness of the two.

**Levirate:** When a wife is inherited by her deceased husband's brother.

**Maternal Orphans:** Children who have lost their mothers

**Matrifocal/Matricentric families:** Sometimes the term female-headed household is used to describe family units where fathers/men are marginal or completely absent and where mothers/women act as the protectors, providers and caregivers. In this research the term matrifocal family is used to overcome the conceptual problems related to the family/household dichotomy.

**Neolocal residence:** A situation where married persons establish their residence apart from either the husband's or the wife's parents' residence

**Nuclear family:** Same as the conjugal family and consists of a husband, wife and their dependent children

**Split Households:** These are households that come about when members of a family migrate but still send back remittances. There is still some form of resource-pooling and joint decision-making between the households, despite the fact that members are geographically dispersed, as in the case of labour migrants.

**Orphans and Vulnerable Children (OVC):** Children under eighteen who have been orphaned or made vulnerable as a result of the mortality or morbidity of primary care givers

**Paternal Orphans:** Children who have lost their fathers

**Patrilocal residence:** When married persons live in the locality associated with the husband's father's residence.

**Reciprocity:** Exchange of goods and services between two parties of roughly equivalent value

**Sororate:** When the deceased wife's family compensates the husband for his loss by sending another (normally younger) sister of the deceased wife to take her place. This can also be done in cases of infertility.

**Susceptibility:** Refers to the predisposition of contracting HIV and AIDS as a result of certain physiological or social factors

**Vulnerability:** Refers to the deferential abilities of individuals and social groups to mitigate the impact of AIDS

## **Chapter 2: Methodology**

### **2.1 Epistemological and Methodological Issues**

#### **a) Distinction between research paradigms, methodologies and methods**

The literature draws a distinction between research paradigms, methodologies and methods of data collection. A research paradigm is generally associated with meta-analysis and is based on the researcher's world view. This includes the explicitly stated and implied value commitments, beliefs and conceptual frameworks shared by researchers and that guide their approach to research. (Sarantakos, 1997:31-71) An overall world view influences the methodological choices. This has been at the heart of what is called the *methodenstreit*.<sup>ii</sup> (Jary and Jary, 1991) The most well known and frequently applied research paradigms that have established themselves as distinct and different from others are Positivism, Interactionism/Hermeneutic Approaches and Critical Theory. (Sarantakos, 1997, pp. 31-71)

Methodology refers to the overall logic of the research design. The researcher can follow a certain research logic that leads to particular choices between quantitative and qualitative research designs, deductive or inductive logic, probability and non probability sampling, different methods of data collection and analysis. Some of these quantitative and qualitative methodologies include survey research, experimental research, ethnographic research, content analysis, biographical research or grounded theory. (Sarantakos, 1997 pp.31-71; Babbie, 2002, pp. 32-59)

Research methods on the other hand are more narrowly defined tools/instruments of data collection or investigative techniques like the questionnaire, focus group discussion, key informant interview or the life history interview. Some research instruments are clearly associated with certain

methodological approaches. For example the questionnaire is closely associated with survey research. (Sarantakos, 1997, pp.31-71; Babbie, 2002, pp. 32-59)

### **b) Methodological Pluralism**

It is possible to adopt a methodologically pluralistic and pragmatic approach. This type of pragmatism is more interested in the question of what is the best way of answering the particular research question, rather than an unwavering commitment to a particular methodology irrespective of the research question or research context. Pragmatism is more concerned with what is most appropriate in a particular research context. This means the researcher could employ various forms of inter-method or intra-method triangulation or even cross boundaries between paradigmatic traditions.

This research design leans towards methodological pluralism. The researcher combined two different methodological traditions, namely critical theory with qualitative ethnographic tools for empirical data collection. The critical approach was primarily applied in the review of theoretical and international literature. The critical approach to social science starts from the premise that dominant accounts in the literature do not adequately help to understand the problem. (Fay, 1993) It does so in the hope of exposing power relationships that circulate within the scientific statements or knowledge claims. (Foucault, 1970; Said, 2003) In this research, the researcher applied critical analysis to the dominant HIV and AIDS narratives in order to expose the structural and systemic conflicts and contradictions that fuel the spread of HIV and AIDS. These contradictions are often concealed in hegemonic accounts of the phenomenon.

While Critical Theory with a capital C is associated with the Frankfurt School, its influence has stretched beyond the confines of Marxism to include other areas of critical social science associated with emancipatory, goal-directed social enquiry, including Feminism, Post Structuralism and Post Colonial

Theory. (Bohman, 2005) Post Structuralists like Foucault (1970) and Said (2003) argue that the process of knowledge construction is not value neutral, but reflect relationships of power. This researcher partially agrees with this epistemological insight and also has applied it to the literature in order to understand the knowledge-power nexus that circulates in HIV and AIDS discourses.

In the positivistic tradition the researcher is supposed to remain objective and value-neutral in order to minimise normativism in social research. (Sarantakos, 1997) Max Weber argued that complete neutrality is not possible because social research is value-bound. These values are reflected in the choice of the research topic since there are no intrinsically scientific criteria for the choice of a research topic. According to Weber the value relevant nature of the research topic, should however, not invalidate the objective nature of social science.(Coser,1991; Jary and Jary, 1991) Once the researcher has followed his/her “demons” in topic selection, the research process should be objective in the sense that knowledge claims must be subject to empirical verification, and the researcher should not impose value judgements on the data as science cannot validate value judgements, moral choices or political preferences. (Coser, 1971; Jary and Jary, 1991) This view still hangs on to positivistic notions of the researcher as a free floating agent, who can rise above his own social conditions and value commitments to deliver objective knowledge.

Critical social science argues that both value-neutrality and objectivity are unattainable, unnecessary, undesirable and an excuse for the uncritical acceptance of the status quo. (Sarantkos, 1997) Critical social science accepts that social science is normative since it does not only concern itself with what is, but also with what ought to be. It is therefore more honest to acknowledge the researcher’s value commitments, and to state them openly, rather than to deny that they exist. (Sarantakos, 1997) Critical social science tries to overcome the dualism between philosophy and social science, explanation and

understanding, structure and agency, as well as regularity and normativity. A well known exponent of Critical Theory, Horkheimer, attached three criteria to critical social enquiry i.e. it must be explanatory, practical and normative all at the same time. (Bohman, 2005) This implies an interdisciplinary interplay between philosophy and empirical social science.

In the case of this research study, the researcher acknowledges her commitment to a social transformation that will end the suffering of people adversely affected by the impact of HIV and AIDS. To this end the researcher critically interrogates the literature and practices which present AIDS as a personal and medical problem rather than a social and political problem. The researcher emphasises the latter precisely because the dominant discourses on HIV and AIDS often conceal this under the guise of objectivity and therefore fail to explore circumstances of domination and oppression.

To meet the condition that social enquiry should contribute towards new knowledge, the researcher conducted empirical research by employing qualitative methods of enquiry. The choice of more ethnographic methods of empirical enquiry was motivated by the researcher's desire to avoid foreclosure. Consequently, no hypothesis was developed for testing since this has the propensity to confine enquiry to *a priori* postulations.

#### **b) Reconstructing Indigenous African past**

Another important methodological issue that required consideration is the ethnographic reconstruction of Africa's distant past and indigenous history. There is a lack, and in some instances a complete absence, of written history. Outside of archaeological evidence, social scientists who wish to tap into that past must do so through the ethnographic present. This means through observing the present. This is primarily done through field studies in rural Africa and through oral history. (Austen, 1987) These can only provide limited insights. To date the methodological tools that can help unravel

Africa's distant social history, including social institutions like family structures with absolute certainty, remain elusive. The author accepts that the use of oral history to gain some understanding of past Namibian family forms has limitations and can only provide tentative and partial explanations. To some in the positivistic tradition this may be unsettling, as Positivism seeks firm foundations for our knowledge claims. This has the danger of limiting enquiry to what is observable and certain. However in some exploratory journeys of enquiry one cannot always be certain, and knowledge claims can and should be subjected to contestation. The aim of including reconstructed accounts (based on oral history) is mainly to seek some plausible explanations with the understanding that they can be contested by future researchers.

Despite having acknowledged that all knowledge can be subjected to contestation and may not always have the certainty epistemological foundationalism seeks, this researcher is committed to seeking the evidence that can support her knowledge claims, and is committed to corroborating that evidence through multiple lines of enquiry and the use of multiple sources. As far as possible the researcher, therefore sought empirical verification, to all knowledge claims. What the researcher freely concedes is that the tools available for investigating the distant past of non literate societies cannot yield absolute certainty.

## **2.2 Literature Reviewed**

Chapters 2-4 were constructed by reviewing the literature related to HIV, AIDS and families. Chapter 2 looks at the relevance and explanatory value of sociological theories in explaining the diverse family forms in Namibia. Chapter 3 reviews the international literature on the impact of HIV and AIDS



on families and households. Chapter 4 is a review of the literature on HIV and AIDS in Namibia and how the available literature explains the impact of HIV and AIDS on Namibian families.

One of the limitations of the literature review was the lack of Namibian-based literature and studies. This research is therefore a venture into relatively unexplored territory. The following literature was surveyed:

**Books and articles** on the historical development of different family forms and sociological theories on family structures

**Books and articles** on the impact of HIV and AIDS on family and household structures that reflect the international experience

**Official statistics** contained in the Population Census, Household Income and Expenditure Surveys and Labour Market Surveys were perused to assess the changes and continuities in demographic trends, household composition and size, forms of marital and sexual unions, household economic activities, dependency ratios as well as forms and levels of household income.

**Research Reports:** on OVC care and the impact of AIDS morbidity and mortality on affected families.

**Newspaper reports,** particularly on HIV and AIDS in Namibia.

### **2.3 Empirical Data Collection: Field study**

Given the lack of previous research on the topic, the empirical component of this research was exploratory and followed a qualitative, inductivist approach. No hypothesis was developed for testing. The existing theoretical frameworks do not explain and theorise the relationship between AIDS mortality, orphanhood and family structure. There was thus little basis for theorising and hypothesising the Namibian experience, or therefore the aim was mainly to describe and explore the relationship

between the two phenomena without foreclosure. Only once all data was collected did the author make some empirical generalisations and conclusions as reflected in Chapter 6.

### **Empirical data collection: Phase 1**

Empirical research occurred in three stages. Each stage of data collection and analysis fed into the subsequent stage. The first stage provided background information on the historical and ethnographic development of Namibian family forms. Since there is a lack of sociological studies, the researcher used oral history research to reconstruct some outline of this history. A total of 340 interviews were conducted, mainly in the rural areas of Namibia. These interviews were done with the assistance of the 2005 and 2006 Social Research Methods students of the University of Namibia, who carried out the research during their first semester mid-term breaks.

The researcher developed the Key Informant Interview schedule, and the students collected data since many came from rural communities and could speak the local languages. Categories and questions were first discussed with the students. After the KII schedule was developed, the researcher studied it with the students, who then provided further input into the development of the instrument (for example the relevance and appropriateness of certain questions and formulations). Once the students were familiar with the instrument, they were requested to translate the section of the schedule (on which they had to collect data) into the local languages of people in their research areas. In most cases these were the ethnic cultures the students came from or identified with.

The students were divided into research groups. The instrument was divided into sections, and each member of a particular group had to interview at least five key informants on a particular section of the instrument, for example courtship and marriage, childrearing, division of labour or dissolution of

marriage. In most cases more than one group covered a particular ethnic group. This increased the reliability of the data. Each student then had to write a research report. The various individual reports were then consolidated into a group report. The researcher used the reports and raw data to construct some historical background on family life in indigenous Namibian communities.

The key informants were mainly elderly people and traditional leaders in rural villages. Despite the limitations of oral history research, both students and key informants found the exercise affirming since it regards aspects of indigenous history as important enough to commit to paper in an environment where so much of Namibia's social history remains unrecorded. There is a grave danger that some of this history will be lost to future generations. The data gathered during phase 1 were worked into Chapters 2, 3 and 4 of this dissertation.

### **Empirical Data Collection: Phase 2**

The second phase of empirical research was conducted between May and August, 2007. During this phase, data on the impact of AIDS mortality on families and households were collected. The empirical findings of this stage of data collection are presented in Chapter 5, and some generalisations and conclusions drawn from this empirical data are presented in Chapter 6. Data collection occurred in the Khomas and Ohangwena Regions. The initial idea of collecting data in the Caprivi Region, due to its high HIV infection rates, had to be abandoned due to the lack of funds.

### **Empirical Data Collection: Phase 3**

Since data collection and analysis occurred in a cyclical process, there was a need to return to questions that cropped up in the third phase of data collection. Data analysis revealed insufficient empirical data on these questions. One question that was particularly important in this phase was why

certain families in the rural area that experienced AIDS mortality were so large. Common sense would lead us to assume that AIDS mortality would decrease family size. This, however, was not always borne out by the empirical data collected in the field. It was therefore necessary to return to the field to understand this paradox. Twenty household heads of large AIDS-affected families were interviewed to get a better understanding of the composition of these families and the reasons why they were so big. Data collection occurred between April and May 2008.

## **2.4 Methods of empirical data collection (data collection techniques)**

Different quantitative research instruments were used to collect the empirical data:

**Key Informant Interviews (KIIs):** KIIs are normally semi-structured interviews that are conducted with experts in a particular setting or community. In phase one KII /ethnographic interviews were conducted with old people and traditional leaders, because it was assumed that they are the most accessible custodians of history and culture in the absence of written material. As stated previously, 340 persons were interviewed during this phase between 2005 and 2006.

In the second phase KIIs were conducted with experts who worked in the community and provided services to AIDS-affected families, namely: nurses, social workers, community mobilisation officers as well as CBO, NGO and ASO programme staff. The type of data generated with this instrument gave a general overview of the needs of OVCs, the difficulties experienced by families, and survival strategies families and the communities develop in response to the increased dependency burden caused by AIDS. It also served to corroborate the data collected from other sources, and thus increase the reliability and validity of the study. During the second phase of data collection a total of 25 KIIs

were conducted between June and August 2007. Eight of these interviews were conducted in the Khomas Region and 17 in the Ohangwena Region.

**Semi-Structured Interviews: (SSIs)** were conducted with heads of families or households that were caring for orphans or sick people. The SSIs were used in the second and third phases of data collection and were done to obtain information on the impact of mortality and orphanhood on affected families from those families that were affected by these issues. In the second phase of empirical data collection 22 household heads were interviewed in the Khomas Region and 16 in the Ohangwena Region. Interviews were conducted between June and August 2007. In the third phase of data collection an additional 20 SSIs were conducted specifically with household heads from large AIDS affected families. These interviews were therefore conducted only in the Ohangwena Region between March and April 2008.

**Focus Group Discussions (FGDs):** FGDs were conducted with groups of children who have been orphaned or made vulnerable by HIV and AIDS, to capture their views and experiences. In the research design the rationale for using FGDs was to cover a large number of children in a relatively short period of time. However in the field some FGDs were converted to SSIs, as the children were often inhibited by the presence of others. They also mimicked or repeated the answers and experiences of others. This raised questions about the reliability of the data, and therefore the researcher decided to switch to SSIs, so that children could be interviewed individually. In the Ohangwena Region the first two FGDs, comprising six children, were conducted in group interview format. The rest of the twenty three children who were interviewed in this region were interviewed individually, but the same FGD instrument was used as in the group interviews. Due to logistical reasons (the number of children who arrived at the home of the community worker at the same time), FGDs in group format were done with

children interviewed in the Khomas Region. A total of six FGDs comprising a total twenty three children were conducted in the region.

**Memos:** During the course of empirical data collection, the author made notes of observations and impressions. The notes contained experiences, observations, logistical problems, theoretical insights as well as methodological and ethical dilemmas.

## 2.5 Data Processing

The following steps were followed to process and analyse the data:

- **Transcription of interviews:** Data from the three phases of fieldwork were transcribed from rough notes and recordings onto paper.
- **Checking and editing:** Data was cleaned, checked and edited to eliminate inconsistencies. Every evening after fieldwork the researcher checked the data and made sure that responses were clear, since there were lots of translations, and this at times had to be checked with interpreters.
- **Data Coding:** The following forms of coding were done:
  - Open coding-- to develop an initial basis for classification, categorisation and conceptualisation.
  - Axial coding-- this followed initial open coding in order to identify the central issues and the context and to delineate consequences.
  - Selection coding in order to integrate all the information and to develop some of the propositions reflected in Chapter 6.

## 2.6 Data Analysis

The analysis was done by establishing the major themes and trends, making comparisons between data sets, making associations between concepts, looking for similarities and differences and explanations. The empirical data were compared with the theories and the international experiences in order to make comparisons and draw linkages between the literature and the empirical findings of this particular research.

The techniques of data analysis used were:

- **Clustering:** This is the process of grouping similar attributes, characteristics and events. The purpose of clustering in this research study was to group and categorise related attributes, events, processes and actions. Clustering is a prerequisite for identifying patterns and for making comparisons.
- **Noting Patterns and themes:** Through the review of the literature the researcher identified the themes for further enquiry in the empirical study. This process became further nuanced with the analysis of empirical findings as the researcher noted new patterns or could confirm the extent to which patterns identified in the literature were applicable to the research populations in this study.
- **Counting:** Miles and Hubermann argue that counting is not at the heart of qualitative research. However, identifying the frequency of occurrence of significant and recurrent events is part of qualitative analysis. They further contend that doing qualitative analysis with the aid of numbers is a good way of seeing how robust one's insights are. (Sarantakos, 1997, p. 324) Babbie (2004) similarly argues that finding frequencies and magnitudes is part of discovering patterns and

making sense of the data. In order to ascertain the main trends, the researcher analysed frequencies and stated the percentage of people affected by a particular attribute. Where the data was quantified, it was used to ascertain the extent to which informants or families were affected by the same or similar attributes. However in general terms, the research did not follow the logic of a quantitative or statistical design, and therefore the findings cannot be extrapolated to the general population since the researcher does not make any claims to representativeness.

- **Noting relationships between variables:** In a number of instances the researcher noted the relationship between variables, such as the relationship between gender and the likelihood of taking care of orphans, or the relationship between extended kin networks and support structures to orphans. In some cases these relationships are displayed graphically in the form of diagrams and matrices.
- **Building a logical chain from the evidence:** From the empirical evidence it was possible to piece together how different events constitute causal chains or follow in chronological order. Such analyses were applied to issues like migration, morbidity, mortality and household dissolution patterns.

## 2.7 Presentation of the data

A number of tools are used to present the data in Chapter 6. Most of the empirical data are presented in narrative form. While the researcher exclusively used qualitative methods of enquiry, the data are at times summarised in tables and graphs or matrices. These are merely visual representations of the data to summarise information or to make analytical comparisons. They do not constitute quantitative research.



## 2.8 Sampling

Throughout empirical data collection, theoretical, non probability sampling was employed. This meant a search for the typical case to allow for the observation of the phenomenon under study. For ethical reasons the researcher worked with the ASO field staff in order to identify affected families, since the researcher could not approach affected people directly. The clients or members of the ASO were those directly affected by HIV related illness or AIDS related deaths. These were the typical cases the researcher was seeking. Since finding the typical case is the essence of theoretical sampling, the rules of probability sampling were not followed, and therefore the findings cannot be extrapolated to the general population. The study can therefore not be generalised to the population as a whole.

## 2.9 Reliability and Validity Checks

### a) Reliability

The triangulation of different methods of data collection was used to verify the reliability of data.

### b) Validity/ Trustworthiness

Two kinds of validity/ trustworthiness checks were employed:

**Face validity:** A check to see if the instruments cover the key categories of information that can explore and describe the phenomenon under observation.

**Content validity:** A check to see if the research instruments cover all aspects of the topics under observation and are generally thought to be important to the phenomenon.

**The triangulation of methods** also served as a means of reliability and validity checking. For example the review of literature helped to check the validity of the various research methods used.

**Pilot Studies:** The research instruments were piloted with three groups of people. The first group consisted of UNAM students, who assisted with the first phase of data collection. The second group were the translators and interpreters, who assisted in the second and third phases of data collection. The third group consisted of NRCS volunteers, who provided HBC and other services to families. The pilot studies were done to check validity and reliability and to improve question formulation, translation and cultural competence.

## **2.10 Ethical Considerations**

The phenomenon under investigation required obtrusive methods of data collection. The information requested encroached upon the very private spaces and intimate feelings of families and the individuals who constitute these families. The researcher had to probe carefully but at the same time make clear at the outset the purpose of the research and the type of information to be gathered. The researcher observed ethics like informed consent, confidentiality and anonymity. Interviews were conducted in the presence of social workers and ASO workers who were known to the interviewees and in a relationship of trust with informants. The ASOs at times served as interpreters but also ensured that their organisations and the informants were not harmed, embarrassed or distressed in any way. The presence of ASO workers was a further advantage when children broke down and cried during interviews when relating experiences. ASOs comforted them and could recommend a course of action or refer the children to the available services.

There were, however, some ethical dilemmas. First, most of the household heads, children and volunteers were impoverished. The researcher wanted information from them but also wanted to give something in return. Under some circumstances this could be construed as buying information, but the levels of poverty and deprivation caused the researcher to make the decision to give food parcels to

AIDS-affected households. The parcels consisted of maize meal, cooking oil, sugar, coffee, tea, tinned fish, potatoes, carrots, and apples and oranges. Children who came to FGDs received a lunch of sandwiches, fish, a piece of fruit and a soft drink. In the case of the twenty large families that were interviewed in the last phase of data collection, the researcher provided some blankets and school jerseys and socks to some of the families. In all cases the gifts or food were only distributed after the data were collected, so that cooperation was not contingent upon the exchange of goods or services.

The NRCS and KWID community volunteers who acted as interpreters were paid for their time and telephone or travel expenses incurred when they had to arrange meetings with their clients in the community or attend interviews.

Interviews were at times conducted at the homesteads of household heads and volunteers. They were also conducted at certain community meeting points, for example under certain trees. Homesteads and meetings were far apart, with sandy and inhospitable terrain. Even social workers complained about the inaccessibility of some of the villages. Access was further complicated by the fact that often there were no road markings or directions. It was only because ASO workers knew the areas well that the researcher was able to gain access.

In the Ohangwena Region the political climate was tense during the second phase of data collection. This was due to the fact that the ruling party was on the verge of a split, and people in the region were mobilised by different factions inside the party. In some instances people wanted to raise these issues, but this would have compromised the NRCS's principle of neutrality, and the researcher had to be very careful not to polarise things further or be seen as partial, since this may have compromised the integrity of the process and the NRCS. Ultimately the researcher was accepted and

gained co-operation precisely because of the respect the NRCS commands in the communities and amongst all parties.

## **2.11 Limitations of the study**

### **Use of Oral History**

This methodology relies on memory, and it is possible that through the generations the memories of the past have been infused with the experiences of the present. The past, particularly the extended family relationships, are often romanticised, and this does not always measure up to reality.

### **Status of the written word**

Social science research privileges the written word over oral accounts of a phenomenon. In Namibian social history most written accounts are those of missionaries, explorers, traders, colonial administrators and soldiers. There are very few sources written by indigenous Namibians. When evaluating the written “evidence”, one must ask who speaks and who is silenced. One must be cognisant that these accounts were constructed by a particular person with a particular background or someone who represents a particular group with particular interests. One must therefore consider these accounts as partial representations of a reality, and that other accounts may not be reflected, or may deliberately have been silenced. Often colonial accounts of history treat the indigenous populations as the absent-present or the invisible of the historical narrative. In some instances the views and experiences of the indigenous populations, particularly women, are completely erased.

**Sampling Bias**

Access to the target population was gained through ASOs. Mainly poor/needy families with limited resources utilise these services. This may have introduced a sampling bias in favour of poor families to the exclusion of wealthier ones who are less vulnerable to the pandemic. It also means that the research could not cover the entire spectrum of family forms.

## **Chapter 3: Theorising African Families: Diversity and Complexity**

### **3.1 Introduction**

Many sociological theories (Engels, 1972; Goode, 1971; Harder, 2002; Parsons, 1971), generated to explain changes and continuities in family structures were developed in advanced industrial societies but incorporating the effects of HIV and AIDS on families into such theoretical frameworks is yet to come. The explanatory value of a theory lies in its ability to establish linkages and causation between processes and to provide some plausible explanation for such processes. Historically sociological theory showed a tendency towards universalising certain family structures and processes as the norm because of the ethnocentric nature of the process of theory construction. Family structures in Europe and North America are often used as templates for theorising all family forms. Leading theorists like Engels (1972) Goode (1971) Parsons (1971) and Van den Berghe (1979) tend towards evolutionary theories that assume a common and universal historical trajectory of family development through rather linear historical epochs.

In trying to come to grips with African family forms, one becomes acutely aware of the lack of material available for scholarship. The different representations of families are not only socio-cultural, historical, or theoretical. A large part of the debate is ideological, for ideological constructs are invoked to describe an ideal rather than a concrete phenomenon. This is often the case with discourses on the idyllic, extended African family with its norms, values, support structures and organisational forms.

The primary debates centre around the historical development of different family forms, the universality of the conjugal, nuclear family and the significance of families as social groups and forms of social organisation. Some of the major problems with theorising African and Namibian forms are how to delineate boundaries between different family forms and how to distinguish family from household groups. The sociological distinctions between families and households cannot always capture the fluidity and transience brought about by migration and different child rearing practices. While it is true that family and household are not necessarily the same, there is great confluence between the two, and as will become clear later in this chapter, strict delineations between the two cannot always capture the fissures, reconfigurations and recomposition structural conditions place on families.

Family identity (how a social group is seen/ recognised as a distinct family unit) has traditionally been based on kinship. Kinship is still the key marker of family identity despite the fact that labour migration, low marital rates, high out-of-wedlock birth rates and polygamous unions have resulted in diverse residential patterns and resource pooling arrangements. Family identity is mainly determined by consanguine, conjugal or affinal ties. In Namibia there are numerous examples of how these ties vary as shared child care responsibilities and diffused residential patterns often separate the biological function of genitor from the social function of parenthood. The concept of household frequently used in social science research becomes a blunt analytical tool when trying to classify and categorise familial groups because of these diverse, resource pooling arrangements, residential patterns and child care practices. There is so much fluidity and confluence between family and household boundaries that is not always captured by household surveys and census statistics. (Russel, 1993)

It is clear that structural conditions like economic mode of production, social class, race, gender and ethnicity shape family forms and processes. In many African societies the violent imposition of the capitalist mode of production on familial subsistence or foraging societies created a complex mix of family forms. The co-existence of a variety of family forms can thus be explained as a consequence of the articulation of different modes of production and the differential social-cultural locations various social groups and strata have within them. AIDS may be intersecting with and contributing to this diversity. The consequences of AIDS may also be challenging traditional family support structures at a time when capitalist penetration has already transformed them significantly. (Jackson, 2002; Mullins, 2006; Barnett and Whiteside, 2002; Andrews et al, 2006)

### **3.2 Functions of Families**

Functionalists like Murdoch (as cited in Viljoen, 1996) and Parsons (1971) argue that the family is universal to all societies and performs the following key social functions (Goode, 1971, p.11; Winch, 1971, p.128; Viljoen, 1996, p. 21; Worsley, 1987, p.144):

- a) Sexual reproduction
- b) Economic reproduction
- c) Socialisation of the young.

The notion that the family plays an indispensable role in the functioning of societies, and that these key functions are essential to it, excludes the possibility of other institutions taking over such functions, but as Aries (1971), Viljoen (1999), and Spiro (1971) show, these functions are not essential to families, and they can be performed by other social agents. Spiro (1971) for example



puts forward the Israeli kibbutz as an alternative form of organisation that can fulfil the functions thought to be essential to the family. In the kibbutz there is little regulation of sexual activity. Adults and children live apart, and while parents play an important emotional role, the socialisation and education of the young is left to trained professionals. The Israeli kibbutz shows similarities to the socialist feminist ideals of Alexandra Kollantai, who advocated the socialisation of childcare and domestic labour to emancipate women from domestic drudgery. (Thomas, 2003)

Parsons drew on psychoanalytic theory to explain the centrality of the family in the emotional development of children and the maintenance of stability in adults. (Worsley, 1987) He endorsed the sexual division of labour in the conjugal family and argued that it fulfils two functions namely, the primary socialisation of the young and providing the basis for the security that stabilises the personality of the normal adult. In his view these functions are performed by the female adult, whose “feminine” role unites the dual capacity of mother and wife. (Parsons, 1971, p. 402) This essentialist and ahistorical argument negates the social constructivist and feminist views that see the division of labour in families as socio-culturally constructed and as an outcome of unequal relationships of power.

Functionalism is equated with conservatism because of its concern with the maintenance of order and stability in society. This concern for stability and order is reflected in how it constructs the family (i.e. the nuclear family) as essential to the functioning of society. Socialists (Engels, 1972; Davis, 1982; Kollantai, 1921; Sacks, 1995;) and Feminists (Firestone, 1998; Hooks, 1984; Millet, 1998; Nye, 1998) have highlighted the role of the family in the oppression and exploitation of women as well as in the maintenance and reproduction of social inequalities. To Engels (1972) the silent revolution of women’s subjugation is linked to the advent of private property and

monogamous marriage. He argues that matriarchy existed prior to private property, but with private property men needed heirs to inherit their property, and through monogamous marriage they gained control over women's fertility and sexuality to assure paternity.

Engels' treatise assumes the convergence of family forms, and he uncritically takes on the Darwinist evolutionary stages approach of Bachofen and Morgan to assume a universal evolutionary trajectory of family forms related to concomitant stages in the evolution of social organisation. (Engels, 1972) Consequently, he accepts Bachofen and Morgan's ethnocentric understanding of human societies. Engels also uses classificatory systems<sup>iii</sup>, rules of residence, and the presence of the consanguine family as proof of group marriage and multiple sexual partnering amongst kin.<sup>iv</sup> He erroneously equates matrilineal descent systems (matriarchal gens) and matrifocality with matriarchy (Mutterrecht) and therefore spuriously concludes that matrilineal descent and consanguine family forms are vestiges of matriarchy.

Engels argues that with the advent of private property the consanguine matrifocal family form (which he erroneously equates with matriarchy) was replaced by the monogamous, conjugal, patrilineal family. However in many matrilineal societies including those in Namibia, patriarchal power was not derived from the private ownership over the means of production, but rather the private accumulation of social surpluses. Most important, productive assets like land and cattle were historically communally or at times corporately owned, but males are/were the custodians and controllers of property. They therefore could accumulate the surplus social product and command the labour of women. Matrilineal inheritance meant that property was transferred to male relatives along the female (maternal) lineage, normally in a descending order from eldest

males to the youngest. Only where there were no eligible male heirs in the kinship group could women inherit property.

De Beauvoir disagrees with Engels and argues that patriarchy is a universal constant in all economic systems, and that woman never had superior power to men. (Nye, 1988) Sacks (1995) defends Engels' views and argues that the emergence of class society should be linked to the accumulation of social surpluses in the hands of family chiefs. She uses the !Kung (Ju/hoansi of Namibia, Botswana and Angola) <sup>v</sup> as examples of hunter-gatherer societies that had no private property, no social surpluses and hence no inequalities in sexual relations. She repeats Engels' assumption that matriarchy preceded patriarchy and concludes that with the abolition of private property the need for families will disappear, for the family will cease to exist as an economic unit. Sacks based her conclusions on her reading of anthropologist Richard Lee's work. Lee (2003, 90), however, repeats that on balance gender relations among the Ju/hoansi were fairly equal. Although early marriage, bride capture rituals and age differentials in first marriages could have disadvantaged women, Shostak (1990, 169) argues that with time the relationship became more equal. She however concludes that despite this relative equality, men still had the edge.

Other interpretations of Lee's work, (Marshall, 1999; Barnard, 1991 and Felton, 2001) indicate that the Ju/hoansi had a relatively egalitarian society. This is ascribed to the fact that through their gathering activities women contributed most to food production. (Felton, 2001, p. 15) So far there is no evidence to suggest that matriarchy existed. In fact Lee (2003, p. 83) argues that although most of the Ju/hoansi practised monogamous marriage, there was a small percentage who practised polygyny and an even smaller percentage that practised polyandry. This concurs with Guerreiro's observation (as cited in Barnard, 1991, p.53) of polygyny amongst the Angolan

Ju/hoansi. Shostak (1990) also reports the existence of polygynous marriages and argues that they are difficult to maintain because they place a strain on resources. The cases of polygyny observed by Lee mainly involved male healers. This denotes the slightly elevated position of healers in a generally egalitarian society. It could also signal some acculturation between the Ju/hoansi and their Bantu speaking neighbours over the centuries. Draper (as cited in Barnard, 1991) noted a tendency towards greater gender inequality for women amongst the Ju/hoansi during periods when seasonal migration ceased. Similar to the beliefs of other patriarchal religions, the Ju/hoansi believed that the male God (/=Gao N!) created the universe. (Marshall, 1999, p. 5) This could signal the superior status awarded to men. This, evidence however, does not support any assertions of matriarchy.

Engels points to an important insight in feminist analysis, namely the role of the family and its sexual division of labour in the maintenance and reproduction of inequalities. Western feminists argue that the family is patriarchy's chief institution. Millet (1998) argues that the family mediates between the individual and social structure and effects conformity and control where political and other authorities are insufficient. The family is the key institution through which patriarchal ideology is transmitted to the young and through which women are controlled, even when they have little relationship with the state. Millet further argues that the family is central to the stratification system and the social mechanism by which it is maintained.

Some radical and socialist feminists foresee the withering away of the family as production becomes socialised, and with it domestic labour i.e. child care and other activities linked to the social reproduction of labour. Firestone (1998) goes further to call for artificial human

reproduction in order to remove the biological reproductive functions from women, in order to end female dependency and subordination.

African feminists have rejected western feminism as anti-family. They argue that kinship relationships are central to African societies, and western feminism's critical stance on families has alienated African women from it. Nhlapo (1991, pp. 113-114) argues that the field of family relations is the one in which Africans construct the foundations of the rest of their lives. African feminists have tended to link women's oppression to colonialism and capitalism. (SWAPO, 1984a & b; Unterhalter, 1984) They by and large cast a blind eye on African patriarchy and its historical trajectory from pre-capitalist societies. In the pre-capitalist familial mode of production women were prevented from owning productive assets and provided most of the productive labour.

In the Namibian-based literature, Becker (1995, pp. 76-77) disputes the notion of women's oppression in "traditional" African society. This is premised on the relative autonomy African women had to control surpluses produced from plots allocated to them by their husbands and the fact that some women of royal descent had some political influence. Hango-Rummukaien (2000) argues that the contract labour system introduced by capitalist social relations destroyed the historical control women had over property and social surpluses.

In some of the discussions on African family forms there is often a hankering to reclaim a distant past, uncontaminated by colonialism. This often leads to the construction of idealised family forms that overlooks the empirical evidence of systemic patriarchy rooted in control over productive assets, the sexual division of productive and reproductive labour, as well as male control over female sexuality and fertility. This exploitation and oppression is justified under the

mantle of African culture and tradition. However, because of colonialism's racist disregard for Africa, its people, and its cultures, there is often reluctance amongst Africans to critique indigenous forms of oppression and exploitation and the role the African family plays in it. Liberal anthropologists refuse to critique it because they fear a racist label. Socialists like Engels have taken up an ethnocentric, social evolutionist position to argue that traditional African societies are essentially barbaric, and that capitalism does indeed have a civilising mission that will eventually lead to a universal convergence of family forms and functions fashioned presumably along European family models.

### **3.3 Composition of Families**

#### **3.3.1 Residential Patterns and Spatial boundaries**

Rules of residence are often used to define the family, as it is assumed that a family shares common spatial boundaries. After analysing family forms in two hundred and fifty human societies, Murdoch (as cited in Du Toit and Van Staden, 1989, p. 104) defined the family as a social group characterised by common residence, economic cooperation and reproduction. This definition lacks a sense of history and social context, for it fails to take into account how family structures have changed over time as a result of broader societal change. Haviland (1993, p. 238) argues that the most drastic changes in family structures in Europe occurred between pre-industrial and industrial capitalist societies where there was a separation of family from the world of work. For white, middle class families this heralded the introduction of the doctrine of privacy in family life, "free choice" in mate selection, the notion of marriage for companionship and an increased nurturing role for women.

The socio-historic nature of family forms is underlined by Aries (1971, pp. 91-104) who argues that different family forms existed throughout European history. He depicts marked differences in family form through space, time and social context. For example during the sixteenth century larger, wealthier households often consisted of kin and non-kin, like servants, apprentices and administrators, who were treated as family under the control of a patriarch. In addition there was little separation of the public and private spheres. Depending on social class, children were either palmed off to be cared for by servants or nannies, sent into apprenticeships to be raised in the master's family or had to work in agriculture as part of the familial unit.

In the U.S.A., where a lot of the theoretical and methodological literature about familial forms originated, spatial and residential arrangements have come to play a role in the definition of a family. The official definition limits a family to two or more persons who are related by blood, marriage and adoption and who live together in one household. (Newman and Grauerholz, 2002, p.7) This however does not take into account the diverse spatial and residential arrangements that emerge in diverse social and historical contexts. Working class families often rely on diverse income sources including child labour. They therefore often reside in larger households comprising kin and non kin in order to pool resources for survival. These expanded households may comprise extended, multi-generational families, combined nuclear families, consanguine families and matrifocal families, where a number of related women raise their children with little help from male partners or relatives.

Kayongo-Male & Onyango (1984, p. 62) and Burnham (1987, p.45) caution against conflating family and household boundaries since kinship relationships, family political economy, cooperation and obligations far exceed fixed spatial boundaries. Jones (1996, pp. 2-11) points out

that particularly in southern Africa high levels of inter-familial and inter-household mobility result in family and domestic fluidity as individuals constantly enter and exit spatial boundaries. In countries with high levels of mobility, particularly labour migration, families are often dispersed across geographical boundaries.

Russel (1993, p. 757) alludes to the ethnocentric bias of Social Science when it tries to find congruence between African family forms and their own universalising categories by imposing axiomatic simplicity on these categories, for example by equating homesteads with households. With reference to African families in Swaziland, she argues that this simplification is misleading, for the Swazi homestead is a frustratingly illusive institution with elastic and permeable boundaries. Census and household income surveys are limited, because they provide a snapshot of people within a particular spatial boundary at a particular point in time.

Faced with similar conceptual problems in Costa Rica, Barquero and Trejos (2005) delineate different levels at which the family can be investigated as a unit of analysis. They use Tarrado's distinction of the family as an analytical unit (theoretical level), an observation unit (methodological level) and as an enumeration unit (empirical level). Census data is often gathered at the observational unit, which translates into a dwelling. This may, however, overlook the complexity of familial relationships involved in the social reproduction of that observational unit. They recommend the *posteriori* construction of family groups based on *in situ* identification and the self perception of members of the group rather than *a priori* categories. They, however, do use the dwelling and place of habitation as the starting point. From there they establish the composition of households and the identification of family groups within households using resource pooling and kinship ties as criteria for establishing classifications, as reflected in their



household typologies below. Out of the twelve household types identified, only two do not have family as their basis.

While Barquero and Trejos show the diversity of household composition and family, their typologies still do not capture the role of migration or reflect how diverse residential patterns impact on household and family composition.

**Table 1: Family/Household Typologies**

<b>Family/household type</b>	<b>Description</b>
Nuclear without children	Head and spouse without children, kin or non-kin
Nuclear with children	Head, spouse, with children, but no other kin or non-kin members
Nuclear single-parent	Head, without spouse/partners, and without non-kin
Extended without children	Nuclear without children, with other kin members, but without non-kin members
Extended with children	Nuclear with children, with other kin members, but without non-kin members
Extended single-parent	Nuclear single-parent with children, with other kin members, but without non-kin members
Extended without nucleus	Head without spouse/partner, and without children, with other kin members and without non-kin
Nuclear composite	Nuclear households, with non-kin members
Composite extended	Extended household, with other non-kin members
Composite without nucleus	Extended without nucleus, with other non-kin members
Single person	Only the head
Non-familial	Head and non-kin members

*Source: Barquero and Trejos (2005: 11)*

Urbanisation, labour migration and wage labour have resulted in rather complex family arrangements that blur the family-household distinctions. Newman & Gruezerholz (2002, p. 154) invoke the concept of split households in a single family to capture the effect labour migration has on residential patterns. When family members migrate, they create interdependent economic units that are part of the same family. This applied to Chinese migrants to America during the second half of the nineteenth century. Unlike immigrants from Europe, the Chinese were denied citizenship and prevented from bringing their wives to America. They were also legally prevented from marrying white women purely because of white America's racist fear of the "yellow peril". (Newman & Grauerholz, 2002)

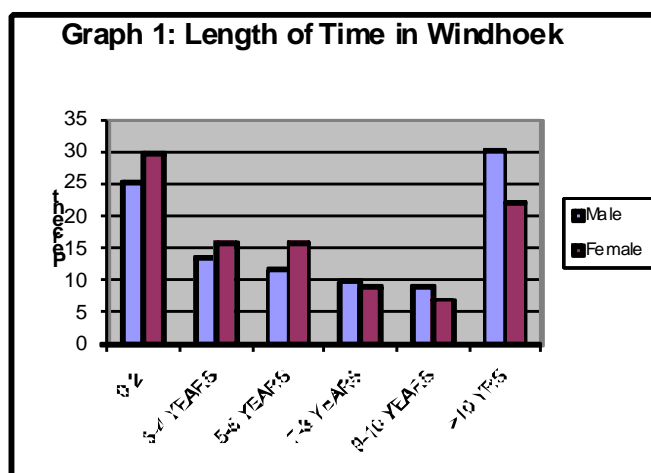
Wallerstein and Smith (1992) draw on empirical evidence to point out the inherent difficulty of establishing conceptual boundaries between households and families, as not all members of a household would necessarily be kin, and not all those who contribute towards family income necessarily reside in the same household. At the centre of what constitutes a family in the Wallerstein and Smith model is the notion of income pooling.

Although influx control regulations have been outlawed since Namibian Independence, labour migration and an articulation of modes of production still result in split households where co-residence only occurs for limited periods during the year. During the colonial period the neolocal nuclear family was the prerogative of Whites. A number of laws restricted the mobility of Blacks, especially black women and children, from taking up co-residence with husbands and fathers in towns. The Native Labour Proclamation (1919), The Vagrancy Proclamation (1920), The Administration Proclamation (1922), The Native Passes Proclamation (1930), The Northern Natives Proclamation (1935), The Native Urban Areas Proclamation (1951) and the 1963 Aliens

Control Act. (Hishongwa, 1991, p. 60) all controlled the movement of black people and prevented their full proletarianisation. For many Blacks the neolocal, conjugal family was legally not possible; hence the spatial separation of black Namibian families. Influx control regulations made black people foreigners in urban centres and black women and children had difficulty sharing common residences with black male husbands/fathers. The articulation of the capitalist and subsistence familial modes of production forced women and children to shoulder most of the productive responsibilities in the subsistence economies.

Independence brought about an increase in female migration. This was facilitated by the abolition of colonial restrictions on black women's mobility. (Winterveldt, 2002) Frayne and Pendleton (2003) and Edwards (2004) show an increase in female migration. This results in further splits in the family as children are left with elderly grandparents, mainly grandmothers. Edwards (2004) shows a steady increase in female migration as depicted in Graph 1 below.

**Graph 1: Comparisons between male and female migration**



(Source: Edwards, 2004)

Labour migration is still very common in Namibia. This can be gleaned from the diverse composition of household income that often consists of wage labour as well as subsistence farming activities. (Republic of Namibia, 2006 a. p. 17) This is particularly the case in Ohangwena and Omusati Regions, where subsistence farming makes up 57 percent and 80 percent of household income respectively. Sociological research, social theory and social policy frameworks that use the household as the unit of analysis often cannot adequately capture these split households that result from dispersion.

Residential patterns are not fixed for all times. In crop growing societies, where women form the primary labour force, like in the former Ovamboland of northern Namibia, there are often initial, patrilocal residence patterns. This meant that the new bride moved to the groom's father's homestead and became subject to his authority. Over time the man would receive land for his own use from the chief. He could then set up his own homestead and marry secondary wives. The residential pattern for secondary or successive wives would therefore be neolocal.

### **3.3.2 Family Ties**

#### **a) Consanguineous or blood ties**

By and large families are constituted of people who share blood ties. In the main people trace kin group membership through biological and genealogical connections. The divide between blood ties and social or non-biological kinship is however obscured by other familial relationships like adoption, fostering, blending, and surrogacy. (Hayden, 2004, p. 380) In some societies the dominant ideal of a nuclear family has a normalising effect. So even when families are not forged on biological grounds, they mimic the same relationships and often take on the form and structures

of families that have been constituted through blood ties, even when biology and procreation is not essential to their construction.

### **b) Conjugal ties**

Levi-Strauss (1971, p. 55) places emphasis on the conjugal bond and argues that at a cursory glance the concept family suggests that it

- finds its origins in marriage,
- consists of a husband, wife and children born in wedlock, but at times other relatives can find themselves living closely to this nuclear group,
- is united by a number of legal, economic and religious bonds and obligations, and
- there is a precise network of sexual rights and prohibitions.

Despite citing a number of ethnographic variations, Levi-Strauss concurs with Goode (1971) and Parsons (1971) that the conjugal, nuclear family is a universal phenomenon. Haviland (1993, p.213) however shows that despite the universality of marriage, it is often not the basis on which family ties are determined. He cites the case of the Nayar in India, where sexual liaisons and paternity do not actually lead to shared residence, obligations, economic cooperation or the basis for tracing descent, since families are constituted consanguineously along the female lineage.

Marriage is not a prerequisite for having children and founding a family. Comparisons between 1991(Republic of Namibia, 1993) and 2001(Republic of Namibia, 2003 a) census statistics in Namibia show that marriage rates are falling. In certain communities and amongst certain social classes there are also high out-of-wedlock births rates. In addition there are historical examples of

how family membership is constituted beyond conjugal relationships. Amongst the Ovaherero and Ovahimba, distinctions between consanguine and affinal relations are blurred due to the practice of cross cousin marriage that consolidates wealth within the kinship group. Amongst Ovambo groups conjugal bonds are important for economic co-operation, but not to determine kinship, since descent is traced matrilineally, and historically a woman and her children were not considered to be the relatives of the husband. (Williams, 1991; Becker, 1995) An adult male's family allegiance primarily resides with his natal kin.

Systems for tracing descent determine inheritance practices. The latter has been a source of family conflict in recent years. Some members of these ethnic groups have experienced class mobility and have consequently accumulated property. They often wish to adopt patrilineal inheritance systems. This is also becoming the case in urban communities. (Le Beau, 2005)

The dominant representations of European family forms construct the hetero-sexual conjugal bond as the fundamental basis of their foundation. Anthropologists have however shown that in single-parent, matrifocal and consanguine families this is not the case. There is an increasing recognition that homosexual unions have challenged the taken-for-granted assumptions about the heterosexual nature of the conjugal bond. Sexual unions in Namibia often range on a continuum from casual sex, temporary and intermittent cohabitation, semi-permanent and permanent informal unions to formal marriage. (Edwards, 2004) This increases the diversity in family form and increases the incidence of multi-generational, extended, expanded and matrifocal families, as children born out of many of these unions are raised by mothers, grandmothers and other kin as indicated in Chapter 4.

### **c) Affinal ties**

Marriage is often the institution that legitimises sexual activity and procreation. However there is an underlying set of contractual obligations connected to the affinal alliances. In many African societies marriage is not only a relationship between individuals, but also an alliance between kinship groups who co-operate economically and provide mutual protection and support to members of the aligned kinship groups. (Mair, 1969) The Ju/hoansi, who for example practiced child betrothals, began exchanging gifts between prospective in-laws a decade before the actual marriage, which normally took place before the girl's first menstrual period. These exchanges (*kamasi*) reinforced relations between the family groups, and the marriage could be called off if the exchange was not kept up by either party. Upon marriage the wife's or husband's siblings or parents could join the family group they were marrying into to become part of that clan. (Lee, 2003) The reciprocal rights and obligations between two kinship groups brought about through marriage amongst other Namibian groups, like the Ovaherero, are reflected in practices like the payment of bridewealth, levirate and sororate.

### **d) Fictive Families**

The Ju/hoansi display examples of how families could be constructed beyond genealogical, conjugal or affinal ties. Naming relations form an interesting aspect of familial relationships. Parents never name children after themselves, nor do they have surnames. Identity is derived from the name given at birth. (Lee, 2003 p. 69) Each person is named after an older relative, alternating between the father's and mother's kin. It could be a grandparent, grandmother, aunt or an uncle. The child then becomes the child of the namesake, and the namesake's children become her/his siblings. (Barnard, 1991, p. 48)

The child also (at least metaphorically) becomes the child of every older person who bears the same name, and if it is a boy, calls elderly men with the same name “father” even if there is no blood relationship. In a system called *wi*, all same sex persons with the same name become the children of elders with the same name, all men with the same name wives can refer to each other’s wife as their wife, and all fathers and mothers of same name children can refer to them as son/daughter. All siblings of other persons with the same name can refer to each other as sister/brother. (Lee, 2003, p. 75) The kinship circle can evolve and grow throughout a person’s life cycle. Neshani Andreas (2001), in her novel, The Purple Violet of Oshaantu, captures a similar phenomenon amongst Ovambo people, where namesakes forge special relationships that often approximate kinship.

### **3.3 3 Familial Relationships**

What is understood to be a family is often an intersecting network of relationships. These relationships can be biological, economic, social, emotional and psychological. These relationships include a set of socially and culturally defined responsibilities, duties and obligations. People who are born into the same family group are likely to retain life-long relationships. (Newman & Grauerholz, 2002, p. 7) The nature of these relationships is determined by the particular socio-cultural context these families find themselves in and how family structures interface with the physical and social environment.

Adams (1971, p.75), scrutinised the structure of the nuclear family and identified three basic relations. They are the husband/wife or conjugal dyad, the mother/child or maternal or biological dyad, and the father/child or paternal dyad. These dyads can occur in varying configurations and can exist inside and outside the nuclear family. For Adams dyadic analysis



removes the prejudices and value judgements inherent in the universality theses. Universalist approaches often construct female-headed households, homosexual unions and single parenthood as pathologies or aberrations. To break out of certain ethnocentric constructions of family form, Burham (1987, p. 42) argues that the diversity of family forms should lead to dyadic analysis as a basis for theorising family structures.

The dyadic approach may not capture the different types of linkages, networks and relationships based on kinship. Parkin and Stone (2004, p. 50) and Ngubane (1987, p. 176) illustrate how the maternal dyad vary culturally. In Zulu culture a person could have a biological mother, a classificatory mother and a social mother to offset infertility and resource constraints related to the payment of bridewealth (lobola). In certain matrilineal groups in Namibia the payment of bridewealth/ lobola ensures that the father can control decision making about the children, for example the use of the labour of children born out of the marriage. However, due to the application of the avuncular rule, the maternal uncle (mother's brother) is responsible for the maintenance and upbringing of the child. It is therefore the maternal uncle rather than the father who will reprimand the child when he/she has violated accepted norms. (Le Beau, Iiping and Conteh, 2004).

In certain cultures relationships are more complex. The Ju/'hoansi, for example, distinguish between joking relatives and avoidance relatives that alternate generationally, depending on whether they are from the same or opposite sex. (Barnard, 1991; Marshall 1999; Lee: 2003) The grandparents could be joking relatives and the parents and the siblings of parents fall into the avoidance category. With the joking relatives one is relaxed and speaks on familiar terms. With

avoidance relatives one shows reserve and respect. This accounts for the high degree of parental authority over children despite the absence of private property.

### **3.4 Diversity of Family forms**

Despite the many typologies and taxonomies used to distinguish between different family forms, there is still great ambiguity. In recognition of diversity and fluidity in family forms, sociological theory has moved from a notion of “the family” towards the concept of family form. Family form and functions depend on a number of factors, of which ethnicity, mode of production, social class and gender are the most structuring. The complexity in family form identification and the difficulties in categorisation are illustrated by Williams (1991, p. 49), who points out that even in one fairly homogenous ethnic group in northern Namibia variances in family form still occur. One homestead could consist of the polygynous family encompassing one man, several wives and their children. Others could consist of monogamous or extended families. The latter could combine three generations in one household. In addition, the composition of an extended family could constantly change. Shortly after marriage a son could take up patrilocal residence until he has accumulated sufficient reserves (normally after one or two years’ harvest) to set up a neolocal residence or until the next son marries and in turn takes up patrilocal residence.

#### **3.4.1 The universality debate**

Arguing from a functionalist standpoint, Talcott Parsons assumed the universality of the conjugal nuclear family and defined “the normal American family” as consisting of a husband, wife and their children. (Parsons, 1971, p. 397) This follows Goode’s (1971, p. 12-17) proclamation of a world revolution in family patterns, resulting in the bilineal, neolocal, nuclear family’s elevation to the

ideal universal family type. Goode assumed that the nuclear family followed the same historical trajectory as industrial capitalism and argued that where society relies less on the exploitation and ownership of land, and more on wage labour, family size would decrease because of the need for greater geographic mobility. The nuclear family form thus facilitates labour and class mobility. Goode argues that an increasing number of people regard this family form as proper and legitimate. Goode (as cited in Winch, 1979 p. 162) identified the disappearance of corporate kinship structures as an anomaly of this convergence and identified some key characteristics of this convergence, namely:

- free choice in mate selection based on romantic love
- dowry and bridewealth disappearance
- marriages between kin becoming less common
- diminishing authority of parents over children
- greater equality between the sexes

Claude Levi-Strauss (1971, p. 50) insisted on the universality of the nuclear family, but opposed the organismic biological evolutionist assumptions underlying Goode's thesis. Skolnick and Skolnick (1971, p. 11) further argue that Functionalism is ahistorical, for it assumes that social structure is determined by social functions rather than arising out of historical and social conditions and power relationships.

Wallerstein and Smith (1992) use the base-superstructure metaphor associated with Marxist analysis to emphasise the centrality of the economic mode of production and social class in shaping the structure of families. They take issue with the evolutionary modernisation thesis, and they dispute assumed progressiveness of capitalism in creating a convergence of family forms and bringing

about an evolutionary superior family form. As World Systems theorists, they argue that family form is dependent on the geo-economic location within the world order and the class position of families within capitalist society. The implication of this argument is that diverse family forms exist along different nexuses of the capitalist world order. They conclude that family structure is a function of social class. Poor people in underdeveloped countries rely on multiple sources of income. This compels many members of the family, including women and children, to contribute towards family income, be it through wage labour, petty commodity production, marketing, subsistence income or transfers. According to Wallerstein and Smith the pooling of these multiple sources of income is an important feature since it affects family and household composition, size and functions.

The geo-economic argument has limitations, for it cannot fully capture differences that result from localised inequalities based on class, race and ethnic stratification within a particular geographic space. Davis (1982), hooks<sup>vi</sup> (1984) and Newman & Grauerholz (2002) point out that African slaves to America were prevented from building stable and secure families since kin were constantly sold and resold by slave masters. There were thus big differences between the white, middle, working class and African slave family structures. (Newman & Grauerholz, 2002, p. 154)

Winch (1979) argues that the following factors influence family form, size, structure and functions:

- environmental potentialities that relate to exploitation of raw materials and the pressure,
- population size which exerts influence on natural resources,
- organisation and division of labour,
- The level of social inequality,
- distribution of surpluses in the economy, and
- Social class.

To make up for the limitations of his universalising theoretical model, Goode (1971, p. 12) concedes that the conjugal family is only an ideal type, which should not be taken too concretely. However, its conceptual dominance in sociological theory has imposed ethnocentric and class biases on our understanding of what families are. It has further created an ideological blind spot on how the family is conceptualised, both theoretically and in policy discourse.

The link between social class and family is demonstrated by Barquero and Trejos (2005), who argue that despite the identification of different nuclear household typologies, only 50% of households in Costa Rica can be categorised as nuclear, because amongst the poor non nuclear family forms are very common. This phenomenon is linked to the unsuccessfulness of the nuclear family to overcome poverty. They argue that under conditions of poverty there is a demographic transition towards older and female household heads. This could partially explain why there are so many poor, matrifocal families in Namibia. A review of poverty and inequality shows that family size, composition, and age structure are important markers of social class. Matrifocal families headed by females are more likely to be poor (30, 4%) or severely poor (15, 1%) than those headed by males. Households headed by persons older than the age of 65 are more likely to be poor. Households that are large (an average size of 6.7 persons) are also more likely to be poor. The review also shows the interrelationship between and convergence between gender, age, size and poverty due to high levels of poverty amongst large households headed by elderly females. (Republic of Namibia-Central of Bureau Statistics, 2008)

Pinpointing family forms in Namibian society may at times be difficult because of the transience associated with labour migration and the fluidity borne out of other socio-cultural

factors. The nuclear family both in its isolated and expanded form is widespread amongst descendants of groups who migrated to Namibia during the nineteenth and twentieth centuries, such as European settlers, mixed groups, for example “Basters” and “Coloureds”, and groups who suffered land dispossession and were therefore forced to find alternative means of subsistence, mainly wage-labour and petty trade.

Modernisation theories assume a decline in family size in the modernisation process. Despite increasing class stratification in Namibian society, kinship ties, family obligations and systems of patronage impose some form of redistribution and reciprocity. Gordon (2005, p. 10) points out that “Kinship as an organising principle has indefinitely stronger power than class, a fact largely ignored in contemporary Namibia”. While class stratification has become more pronounced as a new, politically connected, managerial and educated middle class comes into existence, their separation as class is often impeded by tradition and familial obligations. Often family ties supersede class interests when it comes to reciprocal relations of exchange, duties and obligations. Due to cultural norms and expectations, the wealthy black middle class is often forced to share resources with the extended family. While the nuclear family may be desirable to middle class Blacks, they are not always able to limit their families to the nuclear unit because of restrictions imposed by the systems of obligations and reciprocity that go back for generations.

Systems of obligations and reciprocity could be invoked when the entire kin group contributes towards the further studies of an individual member, who, because of education, experiences class mobility to become a high income earner. Tensions may arise when the middle class individual tries to privatise the gains of that education by keeping income inside the nuclear family. (Nukunya, 1992, p.21)

While the redistributive elements of the kinship system may disadvantage the African middle class most, they may also draw on it in times of need or when they experience downward social mobility, particularly if one considers the lack of state-sponsored social security systems. (Nukunya, 1992, p.11) The African middle class may have been able to assert its emergence through certain symbolic indicators like flashy homes, cars and other life style choices, but familial relations and obligations go much deeper and can be a coercive redistributive force. The tensions between class interests and family obligations may lead to various strategies to escape extended family obligations. In Ghana middle class African civil servants preferred to live in small houses as a way of preventing an invasion of extended kin upon the private space of the nuclear family. (Nukunya, 1992, p. 24)

The question of class formation and changing class structure in Namibian society is under-researched. The new black middle class at times grudgingly concede to the multiple requests from their extended families. People complain about relatives sending children to access better education in urban centres with only the clothes on their backs, relatives requesting contributions towards wedding and funerals or wanting fencing material. There is also the flow of unemployed and under-employed rural relatives seeking better opportunities in urban areas, who need food, accommodation and access to networks of patronage.

### **3.4.2 Polygamous and extended families**

Extended family groups have their material base in the economic mode of subsistence and are normally present in labour intensive agricultural societies or amongst social classes that find it difficult to survive in industrial societies and therefore have to pool multiple income sources. The

matter of what constitutes an extended family, and whether polygamous families are extended families, is up for debate. The extended family can be constituted vertically i.e. inter-generationally with grandparents and grandchildren, or horizontally, i.e. intra-generationally, with people from the same generation, for example brothers, sisters and cousins. The polygamous family is somewhat different, because in Africa it is normally one man who marries more than one wife. It may be intra-generational or intergenerational, depending on the ages of the different spouses. The generational divide may also be blurred, as the family may be comprised of adult children of senior wives, who already have produced children and small children. Younger children born to secondary wives may be the same age as grandchildren born to older children of older or more senior wives. In addition there may be vertical linkages, as unmarried brothers and sisters with or without offspring could still part of the family group. (Livesey: n.d)

Haviland (1993, p. 244) argues that extended families are often collections of nuclear families because each unit should fend for itself. Levi-Strauss (1971, p. 54) argues that the polygamous family “is nothing more than a combination of monogamous families in which the same man plays the part of husband to different women”. It seems a bit far fetched to equate a multi-partner sexual network with monogamy. Levi-Strauss based his argument on the assumption that in a polygynous relationship only the senior wife has legitimacy, and that all subsequent wives are no more than concubines. (Ibid) While each wife in the polygynous union has a separate housing unit in the same compound, cultivates land separately to feed her own children, and disposes of her surpluses independently of the husband or co-wives, they cooperate economically and are under the control of one older male who makes important decisions about land allocation, land use and discipline in the family. Since the polygynous family share lines of



authority, responsibility and identities, they are more extended than nuclear. (Newman & Grauerholz, 2002, p. 8)

Burnham (1987, p. 47) argues that despite opposition to polygynous marriage, the Christian churches are still forced to turn a blind eye on plural marriages. In Namibia polygyny was widely practiced in pre-colonial societies. This was often linked to the dominant mode of subsistence, particularly in crop growing societies where women provided the primary source of labour, and their fertility ensured future labour supply. (Haviland 1993, p. 221) While formal polygynous marriage is on the decline,<sup>vii</sup> the practice of taking multiple wives is not, since formal marriage is substituted by informal unions. Extended families can be linked vertically, i.e. where there is a multi-generational link-up, or horizontally, where multiple conjugal units join, for example brothers, their wives and children. In view of this, Nzimande (1996, p. 45) classifies the polygynous/ composite family as an extended family. If one accepts this definition, then a large number of Namibian families are still extended families despite geographic dispersion. In Namibia around 12, 5 percent of women are in formal polygamous marriages. There is however evidence that formal polygamous marriage is being replaced by non formal “second house” relations that have no protection under civil or customary law. (Le Beau, Ipinge and Conteh, 2004)

Although migrant labour in northern Namibia has weakened the conjugal relationship, the migrant workers were considered part of their rural families and were still responsible for certain forms of household decision-making. (Hishongwa, 1991) Although the population census and other household surveys cannot capture the diversity and complexity of family forms, they provide indications of household size from which family size could be inferred. The 2003/4 Namibian

Household Income and Expenditure Survey (2006, p. 9) points to fairly large households in certain areas. In regions like Khomas (14, 1), the Ohangwena (12, 9) and Omusati (12, 3) large households could be an indication of the prevalence of extended family structures or at the very least expanded households.

Kayongo-Male et al. (1984) point to the difficulties inherent in teleological explanations by arguing that the binarisation of traditional versus modern and extended versus nuclear family forms overlooks the diversity of family forms in society. Embedded in such frameworks are linear modernisation assumptions that family form mirrors industrial development from agrarian rural extended to modern urban nuclear. Burham (1987, pp. 46-47) adds that although marriage may take a monogamous legal character, a host of strategies can be employed to create functional alternatives to formal polygyny. This includes concubines or outside wives. He further points out that there may not be an automatic link between social class and nuclearisation, since highly educated, high income earning males in urban areas may opt for polygyny purely on the basis of economic interests. Under certain circumstances, a combination of an urban professional wife who earns cash salary income and a rural wife who works the land may enhance the man's income sources. In addition, having more wives increases rather than diminishes a man's status.

Russel (2002) admits the difficulty in trying to characterise African families in industrial, capitalist societies. She argues that a combination of land dispossession and livelihoods, as well as the acculturation of the black middle class, may have resulted in a transition towards nuclearisation of urban families, but not rural ones. She further argues that a reduction in family size may occur because of the abolition of child labour in some countries, and the fact that the cost of raising children increases in industrial societies. This may be more acute in South Africa, where

land dispossession took place on a much larger scale than in other southern African countries. Subsistence farming still plays a big part in Namibia, and child labour may still have an important part in it. In Namibia fifty nine percent of the population still reside in the rural areas, forty eight percent of whom live off subsistence farming. (Republic of Namibia, 2003 a) We do not have an accurate reflection of family size since household surveys cannot capture split households within families that emerged as a result of labour migration.

Winterfeldt and Fox (2002) take issue with the nature in which anthropologists like Russel have binarised family forms in Namibia into urban-nuclear and rural-extended, oppositional categories. They make a clear distinction between family based on kinship ties and households that arise out of an economic need to pool resources. They further argue that the rural-urban typology hides the class-specific nature of family form. While they raise an important point about how class is an important factor in determining Namibian family forms, there is an underlying assumption that capitalist production and social organisation replaced pre-existing forms of economic and social organisation when they assert that “The cultural connotations of the family which migrants bring to town, begin to weaken and come under the influence of market rules the family forfeits its existence as a productive unit, becoming almost exclusively a reproductive entity.” Firstly, it is often not families that migrate, but individual members, mainly young males and in recent times increasingly, young females. (Frayne and Pendleton, 2003) Secondly, often family members continue the familial forms of production as recent household surveys indicate. (Republic of Namibia, 2003 a) Thirdly, new migrants often retain multiple identities as wage workers and subsistence farmers for long periods after their migration and may return to their rural family homes in times of unemployment, during vacations, to participate in land clearing, to participate in important family decisions, during illness or for retirement. With AIDS it has

become clear that PLWA often return to the care economy in rural areas when they are no longer able to do productive work. Therefore rather than seeing transitions in families as a mechanistic and linear process, one should recognise the interplay between the changes and continuities structural conditions impose on family structures.

Namibian class formation does not follow the linear trajectory from rural peasantry to urban working class or from working class to middle class. The nature of capitalist development resulted in an articulation of modes production and hybrid, shared and overlapping class identities. In the contract labour system black migrant workers were not regarded as part of a permanent, urban proletariat but a hybrid class that migrated in between the rural subsistence peasantry and the waged proletariat. This results in hybrid identities in space, time and consciousness. The articulation of modes of production <sup>viii</sup> influenced the diversity of family forms that co-exist.

### **3.4.3 Matrifocal Families**

Discussions on matrifocal families or female headed households often contain a pathological narrative, as the absence or marginal presence of men is perceived as a form of deviance. This family form is also presented as an outcome of race, class and ethnicity as it is often found amongst poor black people in Africa, America and the Caribbean. Russel (1993, p. 762) points out that the term “female headed household” is often a misnomer and a result of oversimplification and too little theorisation. She argues that this categorisation assumes discrete households and overlooks the richness and diversity of a range of overlapping domestic groups. In addition household categorisations often fail to factor in labour migration.

In rural Namibian families men are often absent due to labour migration. This is often mistaken for a female headed household, but as Hishongwa (1991, p. 92) points out, males who migrate often remain household heads, and their maternal relatives often control decision-making about their property during their absence, despite the fact that the wives carry out most of the productive labour. The maternal relatives also police married women's sexuality during the husband's absence.

Time and spatial separations do not always lead to the breakdown of family relations or stop the pooling of resources since remittances from urban wage labour often contribute to household income in the rural subsistence economy. Urban workers may also be part-time farmers who still make partial income from animal husbandry. They often return to rural homesteads for extended periods to see to their assets and to participate in productive activities. Their remittances may help to support aged parents. Some of the agricultural production that occurs in the rural areas may contribute towards the household food supply of urban family members.

The female headed households in urban areas often take on the form of single parent, dependent children and co-residents who are often related kin. (Jones, 1996, p. 10) They may also consist of a number of single parent siblings who co-operate economically and who share child rearing functions. (Ibid.) A combination of the sexual division of labour, matrilineal descent, labour migration, economic displacement and poverty has primed sections of Namibian society towards matrifocality.

### **3.5 African Family Structures and Social Change**

Some may argue that it is difficult to pinpoint the timelines and therefore to make clear distinctions between colonial and pre-colonial social structures, since trade and other links exposed African societies to other cultures well before colonial control over African economies. To overcome the problems of periodisation, Nukunya (1992, p. 6) argues it is acceptable to set 1900 as the base year to peg colonial/pre-colonial distinctions, since it was at this time that colonial rule began to affect or influence the bulk of African social institutions. This is particularly the case in southern Africa because of the establishment of settler colonies.

Kayongo-Male et al. (1984) draw the linkages between African family structures and modes of production and argue that the introduction of the capitalist wage economy has thus far had the biggest structuring effect on the African family. Land dispossession and the imposition of taxation led to labour migration, urbanisation, matrifocal or female headed households, the physical separation of families, changes in rules of residence, the formation of non-kinship groupings and more pronounced class differentiation.

Jones (1996) takes issue with the family decline theorists to argue that although African family structures are transforming, they are by no means in decline. In South Africa for example labour migration created a great degree of domestic fluidity while family members retained common family identities, shared experiences and histories. So despite geographic dispersion, members continue to form a support network. Jones however does admit an increasing nuclearisation of African family forms.

Burham (1987, p. 44) shows how capitalist penetration and the monetisation of African societies affected marriage and family structures by arguing that monetisation compels young men to migrate before they marry in order to pay bridewealth that has been monetised. This theme is also taken up by Ngubane (1996) who argues that the monetisation of lobolo amongst Zulu people has weakened women's economic status since it has privatised the transaction between individuals, and women thus have become commodities. Kayongo-Male and Onyango (1984, p. 34) further argue that although urbanisation reduces family size, it has not been to the same extent as in European middle class families, because family networks provide the support systems to new urban migrants.

### **3.6 Families and childcare**

Motherhood, fatherhood and childhood are socio-cultural constructs that should be located ethnographically and historically. With reference to Europe, Aries (1971) for example argues that childhood is an invention of the eighteenth century. Medieval European children were separated from their parents at a young age to be sold off as apprentices and servants. High mortality rates also resulted in high levels of orphaning and step parenting. In early, capitalist, European societies poor, working class children had no childhood. They were often required to contribute towards household income through low-paid and hazardous factory work. (Marx, 1971)

A lot has been said about the centrality of children in African culture. Children often legitimize the marriage. (Mair, 1969) Infertility is therefore often regarded as grounds for divorce. (Edwards, 2007) Namibian society, like many other African societies can be described as a pronatal society. Fertility plays a central role in the construction of both masculine and feminine

identities. People go to great lengths to overcome infertility through consultations with elders, traditional healers, sororate marriage or adoption. (Nakale, 2006) Newly married women without children were historically given a child as a gift upon their marriages to assist with domestic labour. From that moment onwards the parents surrendered authority and responsibilities towards that child, for the adoptive mother's rights over the child superseded those of the biological parents, as is so clearly illustrated in Ellen Ndeshi Namhila's (1997) autobiography. Likewise infertile women were given children by kin to be raised as their own. (Namalambo, 2007)

The centrality of children is linked to their historic role in familial, subsistence, agricultural economies, where women and children formed an essential part of the labour force. Children are also a source of social security to the aged. In some northern Namibia cultures, girls were/are expected to clean the house, pound millet, make baskets, collect water and firewood and take care of younger children while adult females work the fields. Boys are expected to herd animals, hunt, lift heavy things and help with the construction and maintenance of houses. (Taukuheke, 2003) In addition girls are/were valued for the future labour services they would grant their husbands. Their fertility would produce the future labour force, and the lobola/ bridewealth paid to their kin would allow the male members of her kinship group to pay bridewealth and marry in turn. (Mair, 1969, p.6)

Parenthood cannot purely be gleaned from biological connections. Most Namibian cultures do not distinguish between the mother and maternal aunts, because more than one person can perform the role, functions, duties and obligations associated with motherhood. Age distinctions are more important than biological ones. Children may therefore have an array of big mothers and small mothers. In Herero cultures older maternal aunts are called erumbi and younger maternal



aunts omuanu. (Kausiana, 2007) The Oshindonga people refer to the biological mother as meme, older maternal aunts are meme akulu and younger maternal aunts are meme gona. Amongst the Oshikwanyama there are no such linguistic distinctions. Biological mothers and maternal aunts are all simply called meme. (Namalambo, 2007) No linguistic distinctions are made between grandmothers and grandmother's sisters. They all perform the same social and emotional roles. It is still expected that maternal aunts make no distinction between their own biological children and those of their sisters since they all trace their lineage to a common female ancestor. The death of a parent in an intact extended family network historically did not end the maternal dyad since the role of mother was shared by multiple persons. The practice of sororate marriage is precisely based on the assumption that the deceased mother's sister will not ill-treat the children her sister left behind.

Kayongo-Male et al. (1984, p. 19) argue that African societies have a number of socialising agents. Inside the family, parents, older siblings, grandparents, uncles and aunts can take over this function. Inside the community or ethnic group, any adult had the full authority to disciple children. Mair (1969, p. 2) adds that in African societies any woman can temporarily take charge of a child when it is small, and any adult can admonish a child. This is also the case in Namibia with the Ju/hoansi, where all adult members of the community normally share childcare responsibilities. (Haviland, 1993, p. 243) Children are also socialised and disciplined through their peer groups since age stratification is an important feature of African societies. Mair (1969) points out that children were historically taught respect for age and seniority while playing with other children.

Newman & Grauerholz (2002, p. 55) distinguish between individualist and collectivist cultures to explain why in certain communities the well-being of the family group takes precedence over that of individual members. In collectivist cultures, found in certain ethnic groups and social classes, the pooling of resources is central to the survival of the individual. In most African societies the extended family historically provided the social security network to weak, vulnerable members of the society. In matrilineal societies orphaned children become the responsibility of maternal kin, while the paternal kin inherit the deceased father's property. As mentioned before, children are not regarded as the father's kin. (Nzimande, 1996; . Nghiiki, 2006; Nampala, 2005; Ashipala, 2005) The dyadic link between biological father and son is therefore often weak. The social function of a father is separated from the biological function of genitor. As mentioned before, with the application of the avuncular rule, the social function of fatherhood is often performed by the maternal uncles. Children, particularly boys, historically relied on their maternal uncles for support and would eventually inherit primary forms of property from them, as inheritance customarily was not passed from father to son, but from maternal uncles to sisters' sons.

Most African societies have either weak or non-existent, state-provided, social welfare programmes. The family network is the social security network that is mobilised in times of crises or to support the weak and vulnerable. Capitalist penetration of African societies weakened extended family networks. (Nzimande, 1996) Economic displacement caused by colonial dispossession resulted in increased vulnerability. However, despite the emergence of common interest groups like burial societies, savings clubs, trade unions and other community-based organisations, the primary social security function still rests with the family group. The emergence of the neo-liberal, post-colonial state further erodes the little bit of social security that

may have been available in some countries, for the state increasingly withdraws from the provision of social services. In some countries the state is simply too weak or ineffective to deliver such services.

The debate on how to deal with children orphaned or left vulnerable by AIDS has juxtaposed two positions. On the one hand there is an argument for institutionalisation, and on the other side some argue for the strengthening of family structures, i.e. to provide state support so that affected families can cope with the additional burden of care. Namibia's own OVC Policy favours the latter since it is assumed that the affected children's interests will be best served by kin. Institutionalisation is also costly and regarded as unsustainable, given the magnitude of the problem. As is shown in Chapter 4, the care burden is transferred from the state and business enterprises onto the family. While the interests of the OVC may well be best served inside the family structure, there may also be negation of responsibilities by the state. This may explain why (as will be demonstrated in Chapters 3, 4 and 5) the majority of families who have taken in orphans remain poor and have difficulties providing for their basic needs. In many instances the children's vulnerability does not necessarily end because they are in the family structure.

Since African marriages have historically been alliances between groups rather than individuals, group members (Kayongo-Male & Onyango, 1984) were/are often replaceable through leviratic and sororate marriages. In other words, leviratic marriage occurs if a man dies and his brother or cousin who inherits his estate also inherits his wife and dependent children. With sororate marriage, the widower's family can request that his deceased wife's family sends a younger sister or cousin to replace her. Levirate and sororate systems amongst some Namibian groups ensure parenting functions beyond biological dyadic bonds. Parenting obligations can

often be spread across the extended kinship network, and this may account for the frequent migration of children between care givers.

Fostering and caring for the children within the kinship groups has been a longstanding practice even before AIDS. In some Namibian regions only 20% of children under the age of 15 live with their biological parents. Of the thirty six percent of children who do live with either parent, 33% live with their biological mothers and not their fathers, and 4% live with their biological fathers and not their mothers. These residential patterns are influenced by poverty (children are often sent to wealthier kin) and lack of educational facilities in areas of origin. In addition, the system of labour-migration has resulted in parents migrating and leaving children to be raised by grandparents. (Republic of Namibia, 2003 b, p.13)

Urban dwellers have to cope with frequent changes in household composition. In spite of spatial limitations, the homes of maternal aunts and maternal grandmothers often assume the same status as those of biological mothers and grandmothers. Related kin often send their children to be cared for in urban areas, so they can access better education. Historically no distinction was made between brothers and maternal cousins, as the same obligations and systems of reciprocal exchange apply to biological brothers, sisters and cousins. Nukunya (1992, p. 22) and Kayongo-Male & Onyango (1984, p. 26) argue that schooling has greatly reduced the labour value of children and increased the costs of raising them. Land hunger has also resulted in under-employment in a subsistence economy, resulting in surplus adult labour. These factors may affect the willingness of extended families to absorb OVCs into their family structures. (Ntozi, 1997)

### **3.7 HIV/AIDS, Family Inheritance and Reciprocal Relationships**

Matrilineal inheritance systems practised in many southern African countries including Namibia have become a bone of contention because of the “disheritance” of women and children and their subsequent destitution upon the death of the husband, particularly in the context of AIDS-related mortality. Izumi’s (2006) research in Zimbabwe shows that property rights of widows and orphans are not only violated by in-laws, but also by wider communities who enforce customary inheritance laws. Women often give up any claims to property rights in the face of evictions, violent confiscation, threats and beatings by in-laws.

Gordon (2005, p. 5) argues that inheritance plays a major role at a socio-structural level and is an important factor in promoting inequality in society. Furthermore, in the era of HIV/AIDS the inheritance of children has become an important aspect of inheritance. While inheritance could reproduce inequality, as poverty and wealth are often transferred between generations, it could also have redistributive effects. Klocke-Daffa (2005, pp. 39-43) shows that in southern Namibia amongst the Khoekhoen (Nama), extensive reciprocal exchange relationships and obligations that span over generations provide the social security net for vulnerable members of the kinship group.

These exchange arrangements may apply even to those outside the kinship structure. The underlying cultural basis for this is summed up by the dictum that wealth is derived from giving and not keeping. Social standing is derived from caring for the weak and vulnerable rather than amassing personal wealth. Many of the households she studied were comprised of children who were being fostered within the extended family network. These social relationships and

obligations are normally regulated by norm rather than by law. These norms are invoked to develop care arrangements for those made vulnerable by AIDS. OVCs are distributed amongst more stable or wealthier households in the kinship group. Prior to death, meetings are called to discuss the distribution of assets as well as care arrangements for dependents. Death does not end reciprocal relationships and obligations but intensifies them. The reciprocal exchange and obligations network provides the social security network for present and future generations. Klocke-Daffa (2005, pp. 39-43)

In a similar vein Bollig (2005) and Kavari (2005) describe inheritance practices among the Ovahimba and Ovaherero groups. Both these groups have dual descent systems, and property can therefore be inherited matrilineally or patrilineally depending on the origins of the specific item (mostly cattle). Neutral property that the deceased accumulates on his own (property is mainly owned and inherited by men) can be inherited outside the kinship groups. There may be many secondary heirs who inherit smaller portions of the estate, but the main heir of the estate becomes the legal replacement of the deceased. This means that the primary heir also inherits the dependents of the deceased. In this context the widow can be inherited through the practice of leviratic marriage. Amongst the Ovahimba and Ovaherero, the widow, however, can refuse the offer of leviratic marriage, but this carries the risk of being dispossessed of productive assets.

The inheritance ritual involves planting poles that represent the heir and the dependents in close proximity as a symbolic reminder of the heir's obligations towards dependents, so that over time, they grow together to signify the recomposed family. Barnard (1991) argues that systems of reciprocity and sharing are essential to the redistribution of property amongst the Ju/hoansi. Each individual therefore had a network of exchange relationships consisting of *hxaro* partners

and entailing balanced reciprocity and gift sharing. These partnerships historically provided the support people needed in times of distress.

In Ovambo groups that trace descent matrilineally, the wife and children are not regarded as a husband's kin, (Williams, 1991; Becker, 1995) and therefore have no entitlement to his primary forms of property upon his death. Children historically belong to the mother's kin and therefore have traditionally been cared for by her maternal relatives upon her death. (Hishongwa, 1991, p. 41) Maternal relatives may, however show sympathy and pass it on to the children. Children, particularly boys, may inherit personal property like an axe, arrows or spears, but not the primary forms of wealth like cattle. The girls may inherit the mother's beads, clothes or small stock like poultry. (Nghiiiki, 2006) Historically the wife was given a year (one harvest) to return to her kin upon the death of her husband. She would lose access to his cattle and land even if she was responsible for the cultivation of that land and surpluses associated with its cultivation. Traditionally matrilineal inheritance followed certain rules. The first order beneficiary would be the deceased's eldest living brother. If he was no longer alive, inheritance went to his younger brothers. If there were no brothers, it went to the eldest sister's living son, followed by the sister's eldest daughter's eldest son. (Lebert, 2005, p. 75) This is in line with Goody's (2004, p. 111) argument that in Africa, women in the main only inherited male property when there were no males left in the wider kinship group.

Lebert (2005, p. 83) argues that traditional practices are changing. In some instances the wife is allowed to stay on the land, particularly if she is deemed of good character and conforms to culturally constructed norms of femininity. In other instances she is no longer given a year's grace period to vacate the land, but is chased away within days of the her husband's burial, since

inheritance is not passed on from parent to children, and matrilineal heirs do not take responsibility for widows and children.

### **3.8. Family Life Cycle**

In sociological theory the family lifecycle (FLC) represents the various stages and transitions that families go through from foundation through marriage to dissolution through either death, or other forms of separation. This FLC normally consists of six stages as depicted by Harder (2002). This schema is modelled on an ethnocentric middle class family, according to a Parsonian ideal, and is criticised by Barquero & Trejos (2003) who argue that it only considers the experience of the nuclear family based on the assumption that industrialisation and urbanisation will lead to nuclearisation.

Empirical evidence in Latin America shows that, with reductions in poverty levels and higher life expectancy, there is an increasing tendency towards single-person households or adult couples without children. With increased levels of poverty there are, however, higher dependency ratios with more children under the age of 18 in familial households. In situations where there are higher levels of poverty, the extended familial household offers better possibilities of survival.

There would thus be an increase in the incidences of extended and composite households, as households mobilise their most important asset, which is labour, to derive income. Poverty also affects the composition of households and the demographic transition in family lifecycles. An increase in the incidences of poverty increases the number of female headed households. Poor familial households can also show a tendency towards ageing, as poverty delays fissions, and



young people are less able to set up independent households either because of unemployment or lack of resources, resulting in more elderly headed households.

In Namibia, with its high incidence of poverty, there is increasing evidence that the elderly have to sustain families with old age grants. (Republic of Namibia, 2008) Due to high unemployment levels, the old age pension at times becomes the only income for entire families. It is not yet certain what effect the demographic changes brought by AIDS mortality will have on family lifecycles, particularly because of the cyclical relationship between AIDS and poverty.

**Table 2: Family Lifecycle**

<b>Stage</b>	<b>Cycle</b>	<b>Description</b>
<b>Stage 1</b>	Single adult leaves home	Acceptance of independence and self reliance
<b>Stage 2</b>	New couple joins through marriage or co-habitation	Acceptance of new members into the family, establishment of new relationships or realignment of relationships with extended family and the establishment of a marital system.
<b>Stage 3</b>	Families with young children	Extension of family boundaries to accept new members and the establishment of parent-child and sibling relationships
<b>Stage 4</b>	Families with adolescents	Increased flexibility in family boundaries to include independent children and frail grandparents, creation of a middle or sandwich generation between the children and grandchildren, change parent child relationship to allow adolescent children to move in and out of the system.
<b>Stage 5</b>	Launching children and moving on	Multiple entry and exits in and out of the family system, children leave the home or bring in in-laws and grandchildren
<b>Stage 6</b>	Families in later life	Consolidation of generational roles, focus shifts to the middle generation that may still be at stage 5, loss of spouse, siblings and peers and eventual death which brings an end to a generation

(Source: Harder, 2002)

## **Chapter 4: HIV/AIDS, Causality and Mortality: Issues and Debates**

### **4.1 Introduction**

High HIV prevalence rates in sub-Saharan Africa have resulted in a misconception that AIDS is an African disease with black victims. This often plays into the racist narrative of black victims whom retired politicians and western donor aid agencies should rescue. This philanthropy obscures the political and social dimensions of HIV and AIDS. Although HIV and AIDS, like other illnesses work through our bodies, the locus is social. HIV/AIDS has become a metaphor for inequalities, at global, national and household level. Not only are the inequalities reflected in who is HIV positive and who is not, who shall die and who shall not, they are also inscribed in the discourses on HIV and AIDS.

The knowledge-power nexus<sup>ix</sup> privileges biomedical and behaviouralist discourses on HIV/AIDS and marginalises the ones that seek causality in the political economy. It individualises and medicalises what is a social and political problem. The AIDS epidemic, like other diseases, cannot be extracted from its political economy, because how we frame the problem ultimately determines how we propose to solve it. Patton (2002, p.16) points out that HIV and AIDS must be situated in the context of global, regional and local distributions of power and resources, and that policy approaches are far from objective or value free. Dominant discourses often fail to critique the economic order at the centre of these inequalities.

The HIV virus crossed the species barrier more than 70 years ago. (Hunter, 2000 p. 8) The answer to why we have this great epidemic now should be sought in how particular socio-cultural conditions coalesce at a particular historical juncture. It can be assumed that previous localised

HIV epidemics petered out and did not take on the overwhelming dimensions we are witnessing, mainly due to this convergence.

Africa's history of dispossession and underdevelopment, as well as its geo-economic location in the global capitalist order, has largely contributed towards HIV and AIDS taking on epidemic proportions. The impact of HIV on families and households is well documented. (Barnett & Whiteside 2002; Booysen et al., 2002; Van Liere, 2002; LeBeau and Mufune, 2003; O'Manique, 2004; De Vogli and Birbeck, 2005) Poor households are more likely to be affected than wealthier ones, and poor households often carry the burden of impact mitigation. (Nattrass, 2004)

#### **4.2 HIV/AIDS discourses: Individualising and Medicalising the Social**

Four epidemiological discourses on HIV/AIDS can be delineated from the literature.

Namely:

**Bio-medical:** Medicalises HIV/AIDS and locates it within a public health framework.

**Behaviouralist:** Individualises HIV/AIDS as a psychological and behavioural problem driven by individual autonomous choice.

**Human Rights:** Calls for individual sexual, reproductive, treatment and socio-economic rights in the context of liberal democracy.

**Political-economy:** Locates the socio-structural dimensions of HIV/AIDS spread.

Michael Foucault (in Morris and Patton, 1977, pp. 31-32) argues that the great biological image of science still underlies historical analysis, and that it is important to understand what effects of power circulate among the scientific statements. Dominant discourses on HIV/AIDS, albeit well-meaning are

locked into the power-knowledge nexus that posits behaviouralist solutions to HIV spread without addressing its structural drivers. Epidemics thrive under particular socio-historical conditions, and although HIV and AIDS are biological phenomena, the epidemiology of HIV spread is not. (LeBeau & Mufune, 2003, p. 336) Thus far dominant bio-medical and behaviouralist discourses on HIV/AIDS and AIDS have lacked historicity and have either individualised or medicalised the problem. Southern Africa, the epicentre of the epidemic, has experienced major, social, economic and cultural dislocation as a result of colonialism and its forced insertion into global capitalism. This, together with pre-existing forms of inequality (particularly African patriarchy), have contributed to social inequalities, socio-economic dislocation, displacement, migration, mass poverty and a culture of violence. All these contribute towards HIV spread.

Posters and television footage of emaciated Africans posit the narrative of a continent ravaged by poverty, war and disease. Dominant discourses represent Africans as the impoverished war-mongers, who lack the ability to solve their problems. At the same time the powerful industrialised world is constructed as Africa's saviour. However as Farmer (1996, p. 37) points out, parallel epidemiological patterns in North America and India show that HIV and AIDS cannot be extracted from their social and historical context, because like in Africa, the spread of the virus is linked to class, gender and racial inequalities. When trying to understand HIV and AIDS we should not only discuss the HIV, AIDS and Orphan curves, but recognise that these were preceded by poverty and inequality curves.

O'Manique (2004, p. 17) argues that policy approaches to HIV are not politically neutral since knowledge is partial and reflects the vested interests of the actors involved. The dominance of the biomedical discourse in the HIV/AIDS arena signifies its privileged status as knowledge producer. Causality is thus located in the biology of the virus, or if it relates to epidemiology, the question of

lifestyle. The problem is framed within the philosophy of liberal individualism that assumes autonomous, rational free choice. (Fox, 2002) What is essentially a social and political problem therefore becomes an individual or medical problem.

There is a racist sub-text that underlies HIV and AIDS. Farmer (1993, p. 223) traces a discursive tradition that constructs sexually transmitted diseases as black diseases with black victims. The parameters of the debate are often decided by the institutions from wealthy countries that control research, donor funds, publications and the academic discourse and thus shy away from a critique of the global system of economic apartheid that reproduces the inequalities that drive the AIDS epidemic in sub-Saharan Africa.

Well-meaning philanthropists for the African AIDS Crises (Bill Clinton, Bill Gates, Bob Geldof and Bono) have reinforced the racist stereo-type of the hapless African, whose interests must be represented by others. What is missing from these philanthropic accounts of HIV/AIDS is a political commitment to changing the systemic inequalities and economic fragilities that pre-dispose Africa to HIV/AIDS spread, thereby deepening its vulnerability to its impacts. (Harvey, 2003, p.1)

### **4.3 Political Economy of AIDS**

Social-structural conditions related to HIV spread have resulted in the big political debate about whether poverty causes AIDS. Farmer (1999, p. 281) cites Kleinman, who argues that only if we understand “particular worlds of suffering and the way they are shaped by political economy and cultural change can we possibly come to terms with the complex human experience that undermines health”.

Epidemiological patterns link HIV and AIDS to high levels of social inequality, and if consumption rather than income is used to measure inequality, then Africa is the continent with the highest levels of inequalities. (Barnett & Whiteside, 2002, p. 129) The Joint United Nations Programme on HIV and AIDS (UNAIDS), 2007) estimates that globally around 33 million people are living with the HIV virus, of which 68% are in sub-Saharan Africa. In 2007 the global statistics were revised downwards by 16% compared to the 2006 data, due mainly to over-estimation in India and improved surveillance. In countries like Angola, India, Kenya, Mozambique, Nigeria and Zimbabwe there were actual decreases in the number of new infections.

Barnett & Whiteside (2002, p. 125) argue that “Epidemics are products of histories” and that the AIDS epidemic in Africa must be seen against the broad sweep of African history. This concurs with Onimode’s (1988, p. 14) conclusion that any account of the crises in Africa must grapple with the historical origins of African underdevelopment. HIV/AIDS is a long-wave phenomenon with roots in decades, and even in certain cases centuries, of social inequalities. (Barnett & Whiteside, 2002, p. 23) Despite the optimism that the solution to Africa’s underdevelopment lies in globalisation and free trade, Amin (2002, pp. 21-23) points out that Africa’s integration into the global economy should be traced back to 15<sup>th</sup> Century Mercantilism, and that Africa’s particular type of integration into the global capitalist economy is punctuated by the slave trade, colonialism and neo-colonialism, which has turned Africa into the “fourth world” and accounts for its gross underdevelopment.

Mbikusita–Lewanika (2005) concurs that the current nature and practice of trade and investment is part of the global investment and trade linkages of the last 500 years that resulted in

Africa's underdevelopment. This explains why Africa has become the world's poorest continent and why it is particularly hard hit by HIV/AIDS and tuberculosis. The crafted capitalism in southern Africa did not arise out of organic economic development with a concomitant organic development of social institutions. It was an imposition driven by foreign and elite interests at an economic level. For this reason African societies are characterised by fragmentation and dislocation associated with combined and uneven development. There are enclaves of wealth alongside widespread poverty and inequality.

The debate on HIV and AIDS should be injected with the same sense of context. As the evidence will show, The "HIV/AIDS crisis" is more than a health crisis. It has its roots in historical and structural relations of exploitation and inequality. At the same time the epidemic (or rather concurrent epidemics, since there are different types of localised epidemics) exposes the crisis in African leadership (as was shown in South Africa with the leadership's HIV/AIDS denial).<sup>x</sup> In many countries Africa's post-colonial leadership has not been able to resolve the desperate levels of poverty and inequality so pervasive across the continent.

African governments have also bought into the "fiction of neutrality"<sup>xi</sup> of the dominant UN and international donor agency-sponsored discourses that locate AIDS in the behavioural and medical realm. This has resulted in large amounts of money being allocated to rather ineffective and ideologically driven prevention campaigns like the ABC, and constant Knowledge, Attitude and Behaviour Surveys, as if they by themselves can resolve the "AIDS Crises". These campaigns have become subterfuges that distract from the real problem, which is structural. The power-knowledge nexus is often obscured by the notion of "one world"<sup>xii</sup> as embodied by the United Nations and other multilateral agencies.

While UNICEF, UNDP, UNAIDS, World Health Organisation and United Nations Population Fund all lament the devastation HIV/AIDS is causing in Africa, other agencies like the IMF and the World Bank have pursued policies that deepen poverty and inequalities. The latter's Structural Adjustment Policy prescriptions of privatisation, trade liberalisation and contractionary fiscal policies have resulted, amongst other problems, in the following: (Jauch, 1999, pp. 4-6; Barnett & Whiteside, 2002, p. 156; O'Manique, 2004, p. 39; Kaya, 2003, p. 131)

- Net export of capital from Africa to the rest of world (in the form of debt repayment)
- Withdrawal of the state in the provision of services and subsidies
- Displacement of African producers (through dumping, protective tariffs and producer subsidies)
- The privatisation of health care and other essential services
- Increased levels of poverty and lower nutritional standards

Rowden (2005, pp. 21-22) argues that the World Bank and International Monetary Fund (IMF) poverty reduction and macro economic stabilisation frameworks, characterised by the neoliberal Washington Consensus, have failed the poor and led to a decline in per capita income growth rates in Africa. This conclusion is supported by the evidence of other empirical studies (Baden & Millward, 1997; Van Donk, 2004; Weisbrot et al., 2005) In fact Lipton and Maxwell, as cited in Baden & Millward (1997), argue that Africa has seen the greatest increase in the absolute number of poor persons between 1985 and 1990.

Weisbrot et al. (2005, p. 10) show declines in GDP per capita growth rates in sub-Saharan Africa between 1980 and 2000. During 1960-1980, per capita income in sub-Saharan Africa grew



by 36%. In the following twenty years (1980-2000) it fell by 15%. Van Donk (2004, pp. 10-12) further points out that developmental and interventionist, post-colonial African states of the 1950s and 1960s pursued export expansion and import substitution policies to realise sustained levels of growth. The growth in the 1960s was accompanied by significant investments in social and physical infrastructure and capital formation. External shocks (for example oil prices) and dependency on primary products resulted in worsening balance of payments, economic decline and poverty. The 1970s also marked the ascendancy of neo-liberalism characterised by an aversion to state-led development. The decline of the developmental African state was further intensified by the World Bank/IMF-led Economic Structural Adjustment Programmes (ESAPS) of the 1980s-1990s that led to further decreases in growth and an intensification of poverty. (Ibid., pp. 14-15) It is during this period and under conditions of economic distress and dislocation that HIV/AIDS emerged as an epidemic.

#### **4.4 Causal linkages between poverty and HIV/AIDS**

De Vogli & Birbeck (2005) constructed a causality framework that shows the causal relationships between World Bank and IMF stabilisation policies and increased susceptibility and vulnerability to HIV and AIDS. Poverty increases the susceptibility and the vulnerability to HIV and AIDS. Barnett & Whiteside (2006, p. 26) distinguish between susceptibility and vulnerability by pointing out that susceptibility refers to the chances of certain groups being infected by the virus, and vulnerability refers to effects that the virus is having on certain groups in society. Poor people have increased susceptibility and therefore are at increased risk of contracting HIV.

**Table 3: Causal Pathways between World Bank and IMF stabilisation policies and HIV/AIDS**

<b>IMF &amp; World-Bank Policies</b>	<b>Impacts on vulnerable groups and routes of transmission</b>	<b>Countries where impacts were experienced</b>
<b>Pathway 1:</b> Currency devaluation and the removal of food subsidies	-Increased prices, reduced access to food, shelter and basic commodities. -Women more vulnerable to sexual abuse, sexual exploitation, transactional sex and unprotected sex	-Zambia: 50% increase in maize prices. -Zimbabwe: 15% decrease in food consumption in poor households particularly FHH. -Nigeria: 85% of women reduced meals from 3 to 2 times p/d. -Kenya and Tanzania: increase in girls who engage in commercial sex.
<b>Pathway 2:</b> Privatisation	-Job losses, wage freezes, declines in real wages, unemployment and job insecurity	-Ghana: unemployment led to the adoption of risky survival strategies. -Reduced purchasing power and exposed women to sexual harassment. -In Zambia this resulted in increased child labour.
<b>Pathway 3:</b> Financial and trade liberalisation	-Removal of agricultural subsidies -Increases in real interest rates -Reduced access to credit -Declines in rural subsistence -Farming -Migration -Increased female dependency on working males	-Zimbabwe: migration and loss of livelihoods led to an increase in the number of concurrent sexual partnerships. -In South Africa both of the above led to increased commercial and unsafe sex.
<b>Pathway 4:</b> User fee charges in health sector	-Drop in STD clinic attendance. Reductions in STD and HIV screening, use of reproductive health services	-In Uganda untreated STDs increased the possibility of HIV infection due to high co-infection rates.
<b>Pathway 5:</b> User fee charges in education sector	-Girls from poor families often withdrawn from education. -Reduced youth access to education, missed opportunities for HIV/AIDS education.	-Both boys and girls with low educational levels are more prone to abuse and harassment in work situations

(Source: De Vogli et al., 2005, p. 115)

Poor households are less able to absorb and cope with the impact of AIDS. Although poor people are not the only ones infected by HIV, in Africa there are strong interlinkages between poverty and HIV/AIDS. (Van Liere, 2002, p. 2) Poor people carry the greatest burden of impact since the burden of impact mitigation is often transferred from the state and business enterprises to poor households. Poor households also lack resources and are less able to absorb the impact.

Drawing on the results of a comparative study between HIV/AIDS affected and unaffected households in Welkom and Qwa Qwa in South Africa, Booysen et al. (2002) argue that lack of infrastructure, poor services, and poor living conditions increase vulnerability to HIV/AIDS-related impacts. The study also shows that affected households are more likely to be poor, and that these already poor households absorb up to 90% of caring responsibilities for the sick. AIDS-related deaths occur mainly in the 15-49 year age group. This affects household income since these are economically the most active people. The literature also shows an increase in the expenditure of AIDS-affected households as a result of increased levels of morbidity and mortality, savings depletion, increased levels of household debt and increased levels of school drop-out rates

Farmer (1996) refers to the structural violence of poverty to emphasise the degradation in which so many of the world's people find themselves. Various governmental and NGO reports present the devastation caused by AIDS as *a fait accompli*.<sup>xiii</sup> Like mass poverty, it is presented as natural and inevitable. A huge industry has emerged around HIV prevention and impact mitigation, but resources are not allocated to address the problem at a structural level.

In South Africa, former President Thabo Mbeki perverted the structural argument when he questioned whether HIV (the virus) causes AIDS (the illness). He argued instead that poverty was the cause of AIDS. (Gumede, 2005, p. 149) The position caused embarrassment and international condemnation. This denialism hampered prevention programmes and stalled treatment roll-out, which resulted in unnecessary loss of life. The debacle in a way reflects an epistemological dilemma of where to locate causality and thus how to develop effective responses to the pandemic.

On the one hand Mbeki wanted to move away from the racist narrative that constructs AIDS as a black disease which reinforces prejudice and racist notions of Africa as a hotbed of all conceivable pathologies. On the other hand, he wanted to absolve the state from its responsibility to provide treatment to people living with AIDS (PLWA).

At a biological level the HIV virus does cause AIDS, but it is under conditions of poverty that people become vulnerable and susceptible to HIV infection. While Mbeki overlooks the linkages between the bio-medical and social structural, he does provide an important insight, namely, that one would have to address the high levels of poverty if one wanted to address the spread of HIV. Ironically, he reinforces the image of hapless Africans by holding out the “begging bowl” for donor funds to address high levels of poverty and inequality. At the same time he casts doubt on the ability of the African state to respond effectively to the HIV epidemic.

In his NEPAD Programme he calls for more structural adjustment and neo liberal inspired economic policies, which others (Bond, 2005; De Vogli & Birbeck, 2005) have demonstrated increase levels of inequality and therefore susceptibility and vulnerability to HIV/AIDS. Poverty results in inadequate nutrition, which in turn increases susceptibility to infection and increases the infectiousness of HIV positive persons. (Jackson, 2002:61) Poverty also increases the incidences of transactional intergenerational sex, as high income males in privileged positions in society become the “sugar daddies” of women and girls who use sex as an economic survival strategy. Ipinge & LeBeau (2005, p. 35) argue that in Namibia for example, open prostitution where sex is exchanged for money is not the most common form of transactional sex, but rather the exchange of sex for gifts like clothes, food, housing or school fees. This makes transactional sex less visible, but not less pervasive.

Conditions of poverty may also result in poor people not seeking treatment for Sexually Transmitted Infections (STIs). There is a high co-infection rate between HIV and other STIs. Open lesions caused by STIs increase the possibility of HIV infection in penile-vaginal intercourse. (Berer, 1993, p. 20) Poor and dependent women also have little control over condom use, and often condom use is subject to male preference. (Edwards, 2004)<sup>xiv</sup>

AIDS related morbidity and mortality changes household income and expenditure patterns. Children in HIV-affected households often suffer nutritional deficiencies and cannot access health, education and other services. They are also more likely to face abuse and sexual exploitation or to be more susceptible to HIV/AIDS infection themselves. Campbell (2003) uses Bourdieu's extended notion of capital to argue that the unequal distribution of economic, symbolic, cultural and social capital has implications for how people are able to cope with the impact of HIV/AIDS. Poor people are the ones most affected and therefore carry the burden of mitigating impact. Children from HIV/AIDS-affected households often have marginal access to these different forms of capital and are therefore more likely to remain marginalised throughout their lives because of the inter-generational reproduction of such marginality, and thus susceptibility and vulnerability.

Nattrass (2004, pp.151-153) cites various studies that show the relationship between HIV/AIDS, gender and class. A firm-based study in Swaziland, for example, showed an inverse relationship between income and HIV prevalence. Employees in the lowest income band had the highest prevalence rates. On the other hand employees in the highest income band had the lowest prevalence rates. Another study in the Free State of South Africa revealed that people living in households affected by higher levels of unemployment are more susceptible to HIV infection. She

further draws a link between gender and HIV susceptibility, arguing that unemployed people, of whom the majority are women, have a 30-50% higher HIV prevalence than employed persons.

Van Niekerk (2005, pp. 55-59) acknowledges the linkages between HIV, inequality and poverty, but argues that consistent politicisation raises the level of inflammatory rhetoric and moral outrage about injustices and are “irrelevant to devising practical programmes” to assist ordinary sufferers. This typifies the technicist approach that has come to dominate HIV/AIDS policy discourse. It ignores the fact that there are different but concurrent epidemics caused by different drivers. In southern Africa these drivers take on structural dimensions. Policy choices are not accidental but very political. Despite the substantial body of literature (Farmer, 1993, 1996 & 1999; Jackson, 2002; Hunter, 2003; Barnett & Whiteside, 2002 & 2006; Le Beau & Mufune, 2003) that points to the structural drivers of HIV/AIDS spread, our policy choices are often framed so that they become palatable to western donors. Currently donors prefer biomedical and behavioural responses. They are easier on the purse and create the illusion that the problem is being solved. They avoid confronting the uncomfortable truths about poverty and inequality that may offend some in power, particularly governments and donors.

Questions of control and access to resources are very political questions. One can in fact argue that to address the class, “race” and gender inequalities implicated in HIV and AIDS requires a return to emancipatory politics, since the post colonial transition in Africa did not change deep rooted levels of inequality and poverty. In fact, it was under neo-colonial settlements that inequalities often intensified as studies in South Africa have shown. The emergence of social movements around treatment access reflects the political nature of HIV and AIDS. The political

programme of the Treatment Action Group (TAC) in South Africa clearly links HIV and AIDS to broader distributive questions of social and economic justice. (De Waal, 2006)

#### **4.5 Gender, poverty and the patriarchal construction of sexuality**

The agency versus structure debate in sociological theory underlies different accounts of gender and sexuality in Africa. In the debate on HIV/AIDS the role of the subject is central to how we understand women's vulnerability to HIV and AIDS. Post-colonial feminists have criticised the objectification of women from the global south in western feminist discourses and have argued that these women are often cast as passive victims rather than active, creative subjects. However research on the interlinkages between HIV/AIDS and gender in Africa strongly suggests that the role of individual human agency that has come to the foreground in Post Structuralist/ Post Modernist social analysis may be overstated.

Despite high levels of knowledge about modes of HIV transmission and prevention, many women lack control over their own sexuality, since economic dependence, sexual violence and patriarchal sexual cultures diminish their ability to express their own sexual preferences and desires. This includes the right to say no to sex, to decide when they want sex and with whom they want sex, the size of the sexual networks they are part of, and the right to insist on protected sex. McFadden and !Khaxas (2007) argue that the collective socialisation of women diminishes their individualism, exacts conformity and silences their voices.

McFadden and !Khaxas's (2007) groundbreaking research in Namibia's Caprivi Region lifts the veil of secrecy around the sexual abuse that occurs under the rubric of African culture and

highlights a number of intersections between HIV/AIDS and patriarchal sexual cultures. These practices are not restricted to the Caprivi Region and can be found in a number of southern African countries. They concluded that in patriarchal cultures matters of sexuality brutalise women into a denial of their own personhood and violate their bodily integrity. Some of the sexual rituals and practices that interface with HIV/AIDS are:

- **Female Initiation**

In the Caprivi Region there are two practices related to female initiation, Sikenge and Mulaleka. Sikenge is an initiation ritual that begins with the onset of menses. The girl is taught that silence and obedience is a natural part of womanhood. The girl is isolated from the rest of the household, for she is considered dirty. This impurity it is believed would affect males negatively. During this time (which could last up to a month) she is prepared for her sexual and reproductive role, and how to give pleasure to her future husband. Through verbal abuse, beatings and scarring she is “tamed”. The grandmother oversees the initiation process which includes the scarring of the back, arms and abdomen. Various herbs are then rubbed into the wounds to make the girl sexually powerful, so that she could keep her man. According to McFadden & !Khaxas (2007), Sikenge provides multiple opportunities for HIV infection to occur through beatings, whipping, and the mutilation of the labia.

Mulaleka is the actual initiation into sex. This initiation is an incestuous sexual encounter where the grandfather, uncle or sometimes brother has sex with the teenage girl with the full consent of the grandmother. This is referred to as sexual testing. The act is then convoluted as fantasy, for the girl is later told that she only dreamt it. This practice is a violation of the Namibian law and amounts to statutory rape, but is enforced by the cultural norms that are at odds



with various conventions that protect children's rights. This early sexual debut provides opportunities for unwanted pregnancy as well as STI and HIV transmission.

- **Widow cleansing/ Kahoma**

There is a belief that a widow who has recently lost her husband should be cleansed through sexual intercourse with a man. The patriarchal narrative that underlies this practice is that an unclean woman will eventually cause men to suffer, lose weight and eventually die. Once again this ritual provides opportunity for HIV transmission, as the widow's husband could have died of AIDS, or the man who "cleanses" her could be HIV positive.

- **Dry Sex**

This is tightening of the vagina through the insertion of herbs and herbal powder to rid the vagina of fluids. Vaginal fluids are often regarded as unclean. The dry vagina is then forcefully penetrated. This causes ruptures and lesions that increase the possibility of HIV transmission.

- **Polygamy and the sexual culture of concurrent partnerships**

There are other insidious forms of control over women's bodies that stem from women's economic dependency and the socio-cultural regulation of their sexuality and fertility. Male control over women's bodies is legitimised by culture and tradition. Women often do not contest this control because of economic dependence, the fear of being ostracised or being labelled un-African.

Despite its oppressiveness, the traditional polygamous marriage provided women with access to the means of production. The introduction of capitalism and Christianisation resulted in a decline in polygamous marriage, but not concomitant decline in the sexual culture of multiple

and concurrent sexual partnering, which still persists unabated Male-initiated multiple and concurrent sexual partnerships fuel the AIDS epidemic. This is justified as the “ways of the forefathers”. Edwards (2004) Although women in stable unions tend to practice monogamy, they often cannot enforce it on their male partners. McFadden & !Khaxas (2007) concur that the polygamous sexual culture is responsible for the high risk, concurrent sexual networks that cause the rapid HIV spread.

In both pre-colonial and colonial societies women’s bodies provided the source of wealth accumulation. In many pre-colonial African societies women provided the main source of agricultural and domestic labour. (Guy, 1990) Women were responsible for household food production, and their fertility produced future generations of labour. In colonial society women’s labour in the subsistence economy subsidised cheap male migrant labour to the market economy. Control over the female body therefore meant control over the primary source of wealth creation. (Edwards, 2007) Polygamy provided males control over multiple female bodies, which came to be a symbol of wealth. In part certain notions of masculinity are still idealised and have been incorporated into contemporary constructions of masculinity.

- **Other risky sexual practices**

African patriarchy has also given rise to a number of sexual practices that make women even more vulnerable. (Jackson, 2002; Talavera, 2002) The payment of lobola/ bridewealth is central to patriarchal control over women’s sexuality. Le Beau and Iiping (2005) and McFadden & !Khaxas (2007) argue that lobola represents an exchange relationship that enslaves and entraps women, because in some cultures women have to double the amount of lobola (either in cattle or

in cash) initially paid for them by the groom's family in order to get a divorce. What this suggests is that bridewealth represents a further impediment to women's autonomy and strengthens patriarchal control.

The fact that the husband's family paid lobola also leads to other practices like sororate relationships, i.e. when the woman's family sends another woman (normally a younger sister or cousin) to replace her if she dies or if she is infertile. Leviratic marriage ensures that the deceased husband's family gains control over his assets after his death. A younger male (brother/ cousin) normally marries the widow and takes control over the assets. (Le Beau & Ipinge, 2004) Women who refuse leviratic marriage can lose all the assets accrued in a marriage as she and her children then have to return to her natal relatives after the death of her spouse. (McFadden & !Khaxas, 2007)

Talavera (2002) also reports that in certain cultures (Ovaherero and Ovahimba) the practice of okujepisa or oupanga makes it socially acceptable for a husband to lend his wife to a male friend or person of high social status to strengthen the male friendship. The reverse is also acceptable when a wife invites her husband to sleep with her female guest.

Poor and economically displaced women at times resort to risky survival strategies. Poverty diminishes women's control over sexual and reproductive decisions (Edwards, 2004; Jackson, 2002; Farmer, 1993, 1996 & 1999; Hunter, 2003; Barnett & Whiteside, 2002) The relative wealth of men over women and the relative poverty of women in relation to men force women into risk-taking survival strategies. (Lowenson & Whiteside, 1997)

Women's vulnerability to HIV was acknowledged by the former UN Secretary General, Kofi Annan, in his 2004 World AIDS Day message when he argued that women bear the brunt of the poverty trap, and that poverty and inequality place them at risk. Despite this acknowledgement, we are still to witness measures that will in fact transform relations of poverty and inequality beyond the rhetoric of women's empowerment. Young women are disproportionately at risk and account for 62% of infected youth. In the 15-24 year age group females constitute 75% of those who are HIV positive. (Joint United Nations Programme on HIV/AIDS (Joint United Nations Programme on HIV and AIDS (UNAIDS), 2004). In South Africa twenty women in this age group are infected for every ten men, whereas in Kenya and Mali it is forty five women for every ten men. The peak age for HIV prevalence among young women is around 25, which is 10-15 years younger than the peak age for men. (International Women's Health Coalition, 2006) This also indicates high levels of inter-generational sex.

- **Violence and HIV Transmission**

Widespread sexual violence like rape diminishes women's control over their sexuality and places them at extreme risk of HIV infection. In unequal societies like those in southern Africa there are high levels of gender-based violence.

High HIV prevalence rates are found amongst migrants, long distance truck drivers, traders, people in the armed forces and displaced persons. The concentration of men from the armed forces who are separated from their families increases the incidences of transactional and casual sex as was reported in Sierra Leone. Civil wars and armed conflict increase the risk of sexual coercion of displaced women and children. Sometimes they engage in transactional sex

with armed personnel like peacekeepers. Women in refugee camps often wander into the woods in search for food or fire-wood. This makes them vulnerable to sexual assault. In conflict situations rape is often used as a weapon of war. This has been the case in the Democratic Republic of Congo, Liberia, Rwanda, Sierra Leone and currently in Sudan's Darfur region. In Rwanda 17% of women who were raped also tested positive for HIV. (Joint United Nations Programme on HIV/AIDS (UNAIDS)/WHO, 2005, p.24)

- **Male sexuality and HIV/AIDS**

There are reports of increasing HIV infection rates amongst men who have sex with men (MSM). MSM is increasingly the case in middle income countries compared to lower income countries. Globally it is estimated that 5-10% of HIV transmission occurs through MSM. There is also an overlap between MSM and men who at the same time have sex with women (i.e. bisexual men). (Agardh et al: 2007) Studies conducted by Johns Hopkins University show that some of the MSM pass the HIV virus onto their wives or female sexual partners. (Cairns: 2009) A study conducted in Namibia show that MSM HIV transmission is lower (12%) than the general population. (Cairns, 2009) This is however not always the trend internationally for in countries like Mexico 57% of HIV transmission occurs through MSM. (Agardh et al., 2007) Where there is discrimination and stigmatisation of MSM there is also the likelihood that these men do not access services. ). (Agardh et al., 2007) In its country report to United Nations General Assembly Special Session on HIV/AIDS (UNGASS), Namibia for example acknowledged that its HIV/AIDS policy is silent on MSM, and that condoms are not distributed in prisons because both sodomy and prostitution are illegal. (UNGASS Country Report, 2007) The lack of policies on MSM reflects a

broader political conservatism that condemns homosexuality as un-African and sinful despite a liberal constitution that guarantees non discrimination and civil liberty.

Research has shown that male circumcision can reduce HIV infection rates up to 60%. Despite initial caution in the face of this evidence, the WHO has now endorsed circumcision as part of prevention. This comes on the back of the University of Illinois trials conducted in Kisumu, Kenya in which forty seven of the 1 391 uncircumcised men contracted HIV compared to twenty two of the one thousand three hundred and ninety three (1 393) circumcised men. These results are further supported by similar studies conducted in Uganda and South Africa. (The Namibian, July 19 2007) It is estimated that male circumcision could prevent 20 million deaths in sub-Saharan Africa over twenty years. (Smith, 2007)

The Chairperson of the 2007 International Conference on AIDS, Professor David Cooper, has hailed circumcision, the ancient surgery that dates back to 2300 BC, as the biggest breakthrough for poor countries, as it can offset the cost of expensive ARV treatment. (The Namibian, August 9 2007)) The initial apprehension in recommending circumcision as a prevention method relates to the serious health implications when circumcision is done by untrained and unskilled practitioners. Countries like Zambia have also been reluctant to endorse male circumcision as a stand-alone “magic bullet” despite the medical evidence that supports its effectiveness. (New Era, May 15 2007) There is also a fear that circumcised men will not use other safe sex technologies like condoms in the belief that circumcision provides sufficient protection.

## 4.6 HIV/AIDS and Migration

In southern Africa colonialism and the introduction of capitalist production gave rise to male labour migration. (Winterfeldt, 2002) In some countries like Namibia and South Africa, colonial restrictions on the mobility of black women ensured that mainly young males migrated to the wage economy. They often left rural sexual partners behind, only to return during vacations. They also started concurrent sexual unions in the areas they migrated to. This trend still continues, but increasingly, single, economically displaced black females are also migrating. Women now constitute almost half of all migrants. (United Nations Population Fund, 2006) Often these women do not find entry into the labour market and therefore turn their bodies into commodities by using sex as a survival strategy. (Edwards, 2004)

The susceptibility of mobile populations is clearly illustrated in the mining industry. In countries as far apart as South Africa, Peru and China, the effects of increasing HIV and AIDS are being felt by the industry. Gold Fields, the fourth largest gold producer, calculated the cost of HIV/AIDS rates at about US\$ 5.00 per ounce. (Stablum, 2007) The ILO calculates that the cost of untreated HIV infection could go up to three times the annual wage of a mine worker due to costs associated with absenteeism, increased health insurance payments and sick leave payments, funeral benefits, as well as recruitment and training costs of new workers. (New Era, July 17 2007)

**Table 4: Factors that contribute towards HIV/AIDS spread in southern Africa**

<b>Biological factors</b>	<b>Personal Factors</b>	<b>Structural Factors</b>
<p>HIV/AIDS is primarily spread through heterosexual intercourse.</p> <p>Mother-to-Child Transmission (MTCT) during lactation or childbirth is the second most common form of HIV transmission.</p> <p>HIV-1C is the most common strain in Southern Africa. It spreads rapidly through heterosexual populations, causes bigger epidemics and mutates faster.</p> <p>Poor nutrition increases susceptibility to infection, and increases the viral loads that increase infectiousness.</p> <p>Co-infection: People who have contracted other STIs are more vulnerable to HIV infection. Poor people with low nutritional status are therefore more susceptible.</p> <p>Due to greater vaginal surface, women have a greater possibility of HIV infection than men.</p> <p>Women are 2-5 times more likely to be infected during receptive penile-vaginal intercourse because there is a greater concentration of HIV in seminal fluids than in vaginal secretions.</p> <p>Male circumcision can reduce infection rates by 60%.</p>	<p>Lack of condom use</p> <p>Inconsistent condom use</p> <p>Multiple and concurrent sexual Partner relationships</p> <p>Substance abuse resulting in risky sexual behaviour</p> <p>Individual fertility desires</p> <p>Stability of sexual union</p> <p>Balance of power in sexual relationships (relative autonomy)</p> <p>Individual assertiveness and negotiation skills</p>	<p>Poverty increases the incidence of transactional sex and multi-partner sexual relationships as a survival strategy.</p> <p>Migration/mobility increases the incidence of casual and transactional sex. It also increases the size of sexual networks and rate of partner change within those networks.</p> <p>Gender inequality places women in a vulnerable position since they are less able to negotiate safe sex. It also increases the incidence of sexual coercion and violence against women.</p> <p>Patriarchal sexual practices like polygamy, wife-lending and wife inheritance increase the possibility of HIV exposure.</p> <p>Sexuality and socio-culturally constructed gender identities influence risky sexual behaviour.</p>

(Adapted from Jackson, 2002)



**Note: Biological factors:** Linked to the types of virus, modes of transmission, the relationship between immune system and susceptibility to infections.

**Personal factors:** Linked to actions individuals can take to prevent infection e.g. practice safe sex.

**Structural factors:** Linked to social-economic and cultural circumstances that encourage risky sexual behaviour.

## 4.7 Effects of HIV and AIDS on Families and Households

### 4.7.1 Introduction

HIV is different from other fatal epidemics because it primarily affects people who are sexually active. This skews the size, age structure and skill composition of the labour force. HIV mainly affects the economically active sections of the population. This affects household income and labour supply. It moves slowly through the population and the human body and involves higher treatment costs than any other disease. (Centre for AIDS Development Research and Evaluation (CADRE), 2000 p. 11)

The different phases in the HIV infection to AIDS progression are as follows: (Harvey, 2003, p. 6)

**Acute Infection:** Takes place 1-6 weeks after infection and is characterised by acute infection causing fever and body ache that clears up spontaneously. In this phase people are most infectious and spread the disease with no possibility of knowing their status.

**Seroconversion:** Takes place 6-12 weeks after infection and is characterised by the production of antibodies that make the detection of HIV status possible.

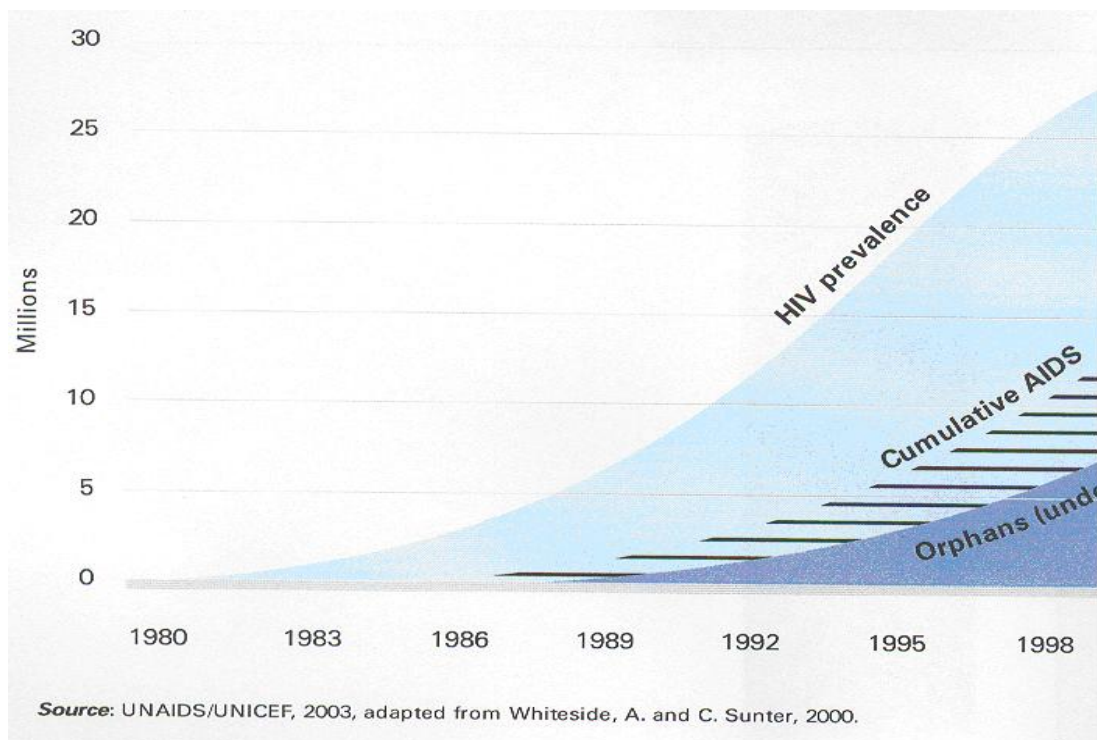
**Asymptomatic period:** Can last several years depending on general health, nutritional and environmental factors. The body does not show any symptoms of infection.

**Early symptomatic infection:** The first symptoms of weakened immunity shown.

**Late symptomatic infection:** Officially seen as the AIDS phase.

The geographic distribution of AIDS mortality reflects global, social and economic inequalities. Sub-Saharan Africa comprises 10% of the world's population but accounts for between 67- 74 percent of the world's HIV infected population and accounts for around 32% of all new infections and AIDS deaths in 2007. (Joint United Nations Programme on HIV and AIDS (UNAIDS), 2007) HIV/AIDS hits poor countries hardest and the poor in those countries who are more susceptible and vulnerable. (Barnett & Whiteside, 2002; Le Beau & Mufune, 2003, p. 348). It presents itself in waves, as depicted in the graph below.

**Graph 2: HIV Prevalence, AIDS and Orphan Curves**



(Source: UNICEF, 2003, p. 10)

#### **4.7.2 Limitations of Prevalence Surveys and Demographic Modelling**

The first wave is the infection wave, where people spread the disease without being aware of the infection. During the second wave the disease becomes visible due to opportunistic infections, often tuberculosis. The third wave is characterised by high levels of morbidity and mortality. The fourth wave is the impact wave, where the effects of the disease are felt throughout the society, but most notably at household level. (Barnett & Whiteside, 2002, p. 23) Different countries may have different localised and concurrent epidemics (for example MSM and heterosexual affecting mainly poor sections of the population). Different countries may also be at different waves or phases of the pandemic.

The Centre for AIDS Development Research and Evaluation (CADRE) (2000) literature survey on the impact of HIV on different sectors reveals some of the difficulty of Demographic Modelling. Since the full impact of HIV is still not clear, a lot of the anticipated impacts are based on prevalence surveys and demographic modelling. Both of these have inherent problems. Firstly, HIV prevalence rates are based on sero-prevalence sentinel surveys that use statistics from antenatal clinics and those seeking treatment for STIs. This may result in some obvious sampling biases. Firstly, it does not include women who use the private sector health facilities. Secondly, it does not include persons who are sexually active, but use contraception. Thirdly, sites used for testing are not randomly selected. Fourthly, only those who grant explicit permission can be tested. All this may skew results. Since 2007 there have been changes in the methodology used to calculate HIV prevalence rates, for example population based surveys and the extension of sentinel survey sites. (Joint United Nations Programme on HIV and AIDS (UNAIDS), 2007)

Demographic models used to anticipate HIV impacts are often based on aggregate data. This may conceal the particular impact AIDS is having on certain groups or household types. The Centre for AIDS Development Research and Evaluation (CADRE) research report (2006, p. 18) shows that there are certain countries with severe epidemics, like Botswana, Thailand and Uganda, that experienced economic growth. This may conceal the inequalities and vulnerability of certain groups and households inside those countries. For example poor rural and urban households may experience growth impacts differently from richer households.

Growth data on their own are problematic since they do not take into account pre-existing levels of poverty upon which that growth is measured. For example Mozambique and Angola showed high levels of growth as a result of post war reconstruction. Growth data do not give an indication of wealth distribution and income inequalities, as in the case of South Africa, where high levels of post apartheid economic growth were accompanied by increased levels of social inequality and poverty amongst certain groups. They may conceal how the burden of impact mitigation has been transferred from the state and business enterprises to households through the care economy. Harvey (2003, p. 15) warns against unsubstantiated aggregation about the impact of HIV/AIDS. Different household types in different situations may be affected differently.

### 4.7.3 Overall effects of AIDS related morbidity and mortality on families and households

Table 5 represents a summary of the impact of AIDS-related morbidity and mortality on families, as constructed from the following sources: Abebe, 2005; Andrews et al., 2006; AVERT, 2006; Barnett and Whiteside, 2002; CIIR, 1999; Jackson, 2002; Mullins, 2001; Ruiz-Casares, 2004; Mutangandura and Webb, 1999; UNICEF, 2004, 2005, 2006)

**Table 5: Effects of AIDS on households and families**

<b>Demographic</b>	<b>Economic</b>	<b>Roles and Responsibilities</b>
Lower life-expectancy	Household's ability to reproduce itself is lessened	Burden of care for the sick and children falls on households and families often on the aged mainly women
Changes in household size and composition	Loss of income due sickness and death	
Dissolution and Recomposition of household	Increased poverty	Children may have to do income generating work to sustain families
Middle generation cut out	Rapid transition from relative wealth to relative poverty	
Multi-generational households without a middle layer	Increased expenditure on medical bills and supplements for the sick	Grandparents may have to care for physical, emotional and educational needs of children
Child Headed Households	Increased funeral costs	
Increased dependency burden	Income diverted from food to items like medication	Extended family members may have to pool resources
Changes in the age structure of households	In rural areas a loss of labour due to morbidity, mortality and care burden	
Forced migration	Loss of labour reduces food production	
Feminisation of AIDS which may change sex ratios	Child labour replaces adult labour	
	Higher school drop-out rates	
	"Disinheritance" of children and widows	

### 4.7.4 Demographic changes and the treatment debate

Farmer (1999, pp. 266-267) describes the failure to roll out antiretroviral therapy as yet another injustice. Lack of treatment is justified by the unrealistic costs, lack of infrastructure or

lack of nutritional prerequisites in poor countries. He therefore argues that failure to treat is often described as treatment failure. In South Africa calls to stop the delivery of Nevirapine to pregnant women in the PMTCT programme illustrates the point. Some women did not adhere to the treatment regime due to logistical problems and the complicatedness of the treatment regimes. (Beresford, 2006) This does not mean that treatment in itself is ineffective, but that the most appropriate delivery vehicles should be sought.

Social movements around treatment access have emerged in the form of Treatment Action Groups or Access Alliances. These groups have exposed injustices related to treatment access and have asserted the citizens' right to treatment. This has resulted in more treatment provision, but access is still far from universal. This is borne out by the high number of AIDS deaths. In 2007 there were 2.1 million AIDS deaths globally of which 1.6 occurred in sub-Saharan Africa. (Joint United Nations Programme on HIV/AIDS (UNAIDS), 2007)

The question of access reflects the deeper problem of the commodification of knowledge and of basic necessities. This commodification is strengthened by various WTO intellectual property rights conventions (TRIPS) that concentrate power in the hands of private corporations and therefore exclude poor people from life saving therapies. (O' Monique's, 2004, pp. 78-79)

In December 2003 the World Health Organisation (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) launched the "3 by 5" strategy which set out the target of providing three million people in low and middle income countries with access to antiretroviral therapy (ARV) by the end of 2005. (WHO, 2006, p. 5) This figure was reached by June 2008, but only represents one third of those in need of treatment. (The Namibian, June 12 2008) These

aggregate statistics conceal huge discrepancies in access to treatment in different countries. Botswana for example provided treatment to more than 50% of those who need it, while Uganda could only provide ARVs to 10% of people who need it. A WHO study confirms the effectiveness of treatment with substantial reductions in mortality rates (up to 93%). In the shanty town of Khayelitsha, South Africa, ARV treatment led to an 83% reduction in mortality rates, despite generally low standards of living. (Jordan, 2007)

In 2001 thirty nine pharmaceutical laboratories instituted legal proceedings against Brazil and South Africa for violating intellectual property rights by introducing generic medicines. The case was dropped due to a moral outcry that highlighted global inequalities in ARV provision and the absurdity of subjecting ARV treatment programmes to the logic of the market. Under the leadership of UN Secretary General, Koffi Annan, a Global Fund to secure treatment in poor countries was established. As an AIDS initiative the Global Fund relied on pledges from rich countries.

US President George W. Bush set up a rival fund, the President's Emergency Plan for AIDS Relief (PEPFAR), to cover treatment programmes in fifteen African, Caribbean and Asian countries. In order to counteract the use of generic drugs and to impose the ideological hegemony of the New Right, the PEPFAR fund imposed two conditions. Firstly, all drugs should be sourced from large pharmaceutical companies. Secondly, prevention campaigns should be based on abstinence. (Eboko, 2005, pp. 721-722) In the meantime pharmaceutical companies like Pfizer and Bristol-Myers Squibb have brought down prices. The production of generic drugs has made wider access possible. Despite these advances, the drugs are still unaffordable to many. The price factor, combined with inadequate and crumbling health systems, impedes the universal roll-out of

ART. (The Namibian, June 12 2008) In addition to weak drug procurement and supply systems, the World Health Organisation (WHO) report (2006, p. 29) charges that drug prices remain unacceptably high.

One should welcome the current philanthropic framework for treatment access on humanitarian grounds. However, reliance on donor support presents a risk, as countries most in need have little control over the sustainability of supply. If donor funds dry up, or donors change funding priorities, access funds will be scaled down. This could lead to drug resistance in those who can no longer afford treatment. In October 2008 UNAIDS Executive Director, Peter Piot, predicted that the global financial crises would affect treatment support due to an anticipated decrease in donor funds for treatment access and a decreased ability of low and middle income countries to fund treatment programmes. ([www.kaisernetwork.org/daily\\_reports/rep\\_index](http://www.kaisernetwork.org/daily_reports/rep_index))

The tenuous nature of funding was demonstrated when Namibia's U\$49.1 million five-year funding request was turned down by the Global Fund in November 2006, on the grounds that it was not of sound technical quality. (Maletsky, 2006, b) The decision was later rescinded, but it leaves no doubt about the potential risks of reliance on external sources. In a 1 December World AIDS Day report, the BCC (Radio news, December 1, 2008) reports that the global financial crisis has already led to round nine of the Global Fund being put on hold, and that there has been a shift away from global treatment access targets to national targets, thus shifting the treatment burden back to national governments.

Benatar (2005, p.71) invokes the concept of Civic Citizenship to argue that there is a certain amount of incompatibility between neo-liberal economic policies and the goals of



democracy, and that the over emphasis on the market has eclipsed democracy and social justice considerations. It has also resulted in placing the interests of the world's privileged few over the suffering of others. Thus far the interest of multi-national pharmaceuticals over those of people living with AIDS has dominated access strategies and resulted in the confinement of treatment access to the logic of the market. Even former US President Bill Clinton's interventions on access to second generation drugs subscribed to this logic when he brokered a deal for between 25-50 % reduction in second generation generic drugs from two Indian companies to 66 developing countries. (The Namibian, August 9, 2007)

The debate around treatment access is politically loaded. On the one hand social movements have asserted the right to life of citizens and therefore demanded universal access to life-prolonging therapies to everyone who needs them. There is also a school of thought that argues that universal access to ARVs will increase HIV prevalence and invoke a causal cycle, as those on treatment will live longer and therefore spread the virus further, which will result in further expenditure on the treatment programmes for incurable diseases. Natrass (2004, p. 13) points out that the economic benefits of people living longer, more productive lives may outstrip the treatment costs. This is based on the assumption that those who are seeking treatment are also active in the labour market or can be absorbed into productive activities.

In response to concerns that increased life expectancy will lead to increased infection rates, WHO (2006, p. 52) argues that treatment and prevention are mutually reinforcing. The WHO cites a study in Uganda that shows that couples who were introduced to antiretroviral therapy also showed a 70 % decrease in risky behaviour. It is estimated that treatment could lead to a 98% reduction in the risk of HIV transmission. The WHO (2006, p. 54) contends that the possibility of

treatment increases the likelihood of testing. Testing in turn creates greater awareness of HIV status, and such awareness could lead to changes in sexual behaviour. A study conducted in Namibia (Edwards, 2004, p. 65) showed that 61% of people who had gone for testing and received the test results on their HIV status said that they altered their sexual behaviour as a result of their knowledge of their HIV status. Nattrass (2005, p. 41) argues that the link between access to treatment and increased risky sexual behaviour is simply moral panic and not grounded in the scientific evidence.

For treatment to be effective it should go hand-in-hand with poverty eradication and food security measures. A case taken up by a public interest law firm in Namibia showed how water privatisation affects treatment adherence. A person could not take her antiretroviral drugs, because she could not cook food, because she could not purchase water through a pre-paid meter system. The head of the South African HIV Clinicians Society, pointed out that water was essential to PLWA for cooking and more frequent bathing, to minimise risks of infections, for cultivations of crops and for taking medicines. (IRIN retrieved August 4, 2006) In other cases people do not adhere to treatment regimes because of inadequate nutrition. There are anecdotal accounts of Namibians selling their drugs across the border to Angolans, because they need immediate cash to purchase food and other necessities.<sup>xv</sup>

The impact of AIDS on families will depend on the extent to which life-prolonging drugs will be available to all who need them. ARV provision can reduce the vulnerability of families and households. Piwoz and Preble, as cited in Harvey (2003, p. 6), point out that there are variations to this, depending on economic status. The length of time between HIV infection and AIDS

diagnosis is 8-10 years in developed countries, and in developing countries this period is shorter as a result of malnutrition, poor health care and exposure to other infectious diseases.

Individual progressions from HIV infection to AIDS is influenced by the person's general immune function.

HIV and AIDS statistical projections are often based on the assumption that all other things will remain equal. However, the post election political crises in Kenya and Zimbabwe revealed other vulnerabilities and fragilities. Internal displacement and service delivery disruptions caused by the conflict cut off some people from the ARV supplies and adequate nutrition that accompany treatment regimes. Disrupted water and sanitation services placed PLWA at risk of opportunistic infections. In addition increased levels of rape and sexual violence during the conflicts and in refugee camps increased the risk of HIV infection for women and children. (MacInnis, 2008)

#### **4.7.5 Changes in family and household composition**

Barnett & Whiteside (2006, p. 207) lament the limitations of HIV and AIDS household impact studies because most of these studies:

- Are concentrated in Africa
- Focus on rural households, perhaps because between 45-85 percent of people in southern African countries live in rural areas (Mutangadura, 2005)
- Are mainly economic
- Use snap shot quantitative survey methodologies that cannot capture processes over time

Despite all these limitations, studies show that AIDS morbidity and mortality result in demographic changes that affect the composition, age structure, dependency burden, income and consumption patterns, life cycles and roles and responsibilities as well the reproduction of the family itself. The biggest impacts at household level are losses in labour supply, losses in income and increases in expenditure. These in turn affect other factors, most notably increased levels of poverty, food security and the ability of a household to reproduce itself. This may then lead to stress migration, household dissolution, recombination and increased dependency ratios.

Barnett & Whiteside (2006, p. 203 & 2002, p. 188) report the following changes in household composition as a result of HIV related adult mortality:

- Grandparent-headed households consisting of elderly household heads with young children
- Unrelated households: These are large households consisting of a number of unrelated orphaned or fostered children
- Child headed households where adults are absent or marginally present
- Clustered households: These are neighbourhood responses in cases where children are cared for by neighbours either on a formal or informal basis
- Single parent households
- Clustered households formed on the basis of kinship or community ties
- Displaced homeless children
- Displaced children in groups or gangs

Mullins (2006, p. 1) uses the term “transient households” to describe the informal resources pooling and living arrangements that groups of people may invoke to survive the vulnerabilities caused by adult mortality. He points out that HIV and AIDS may also lead to the dissolution and recomposition of households. This is particularly so when families are not able to reproduce themselves as economic units, due to loss of income or loss of adult labour. Mutangara as cited in Harvey (2003, p. 26) showed that in Zimbabwe, where there is female mortality, households are more likely to dissolve. Female mortality also increases the levels of malnutrition and the vulnerability of children since women are the primary caregivers. Studies in Zimbabwe and Tanzania show that 42.5% -65% of households dissolved within a year of experiencing adult mortality.

One survival strategy in response to AIDS mortality is for families to send children away to reduce dependency burdens. This was found to be the case in Zambia’s Kafue District. (Mutangadura and Webb, 1999, p. 35) The converse may also be true, as studies in Kenya and Ethiopia show that productive adults from elsewhere may be called upon to join a household that has experienced adult mortality. (Harvey, 2003, p. 15) OVCs may experience multiple migrations as they go through successive orphaning, which could be accompanied by processes of family and household dissolution and recomposition. Firstly, orphans who cannot be absorbed into the rural livelihood system of the extended family may be sent to relatives in urban areas to be cared for. This pattern was observed in Kenya, Zambia and Ethiopia. In countries like Swaziland, Uganda, Malawi and Lesotho the reverse trend can be observed, where children from the urban areas are sent to relatives in rural areas. Other types of urban-rural migrations can be observed, where children need to engage in income-generating activities and therefore migrate from rural areas to

informal urban settlements, where they become vendors, beggars and street children. (Andrews et al., 2006; Adebe, 2005) A recent study in Namibia showed some OVCs become involved in crime and the sex trade. (Kiremire, 2006)

OVCs exposed to successive orphaning are posted to different care giving situations. For example when parents die, they could be shifted to aged grandparents, who in turn may die, leading to other care-giving arrangements. A study in Uganda revealed that one third of care givers of orphaned children were in fact HIV positive themselves. (UNICEF, 2003, p. 22) Some of these situations include living with HIV infected relatives who in turn may also die.

The dissolution and reconfiguration of families and households in southern Africa cannot purely be attributed to AIDS mortality. Particular modes of socialisation within certain kinship groups, and the history of labour migration associated with capitalist development, have resulted in grandparent, single parent and child-headed households. The difference with AIDS mortality is that it not only removes the parent from day-to-day familial life, it also removes remittances, a crucial component of the family's economic base which threatens survival. (Andrews, et al. 2006)

There is no evidence to show that AIDS orphans are being rejected on a large scale. Andrews et al. (2006, p. 272) report that in all sub-Saharan African countries surveyed, 90% of children orphaned as a result of AIDS were taken in by the extended family. This shows the resilience of family structures. However where the extended family structure is weak, orphaned children are more likely to be raised by their grandparents. Fostering children from outside the kinship group is also common.

Harvey (2003, pp. 31-32), Andrews et al. (2006, p. 272) and Mutangadura and Webb (1999, pp. 25-27) all point to the gendered nature of caring. Female-headed households are more likely to take in OVCs than male-headed households. Generally the burden of care rests disproportionately on older women. This could have severe consequences if one considers the feminisation of AIDS. As previously mentioned more women are likely to be infected with HIV compared to men. Women also tend to be infected at a younger age. (Andrews et al. 2006, p. 272)

#### **4.7.6 Dependency Ratios**

The biggest demographic effect of AIDS is the drop in life expectancy, and this increases dependency ratios. (De Waal 2003, p. 8) The available data cannot adequately capture dependency ratios, because they do not track dissolved families, and therefore dependency ratios may be underestimated. (Harvey, 2003, p.16) De Waal and Whiteside (2003, p. 5-9) argue that conventional definitions of dependency cannot adequately capture the phenomenon which demographers typically define as the ratio of adults (between 16-60 years) in relation to the number of children and old people. This obscures the fact that many adults can also be classified as dependents as a result of chronic illness.

There are predictions that reductions in fertility rates will lead to changes in the age structure of the population, and that the neontic (green) dependency ratio will decrease because of decreased fecundity caused by illness, increased condom use and the use of other safe-sex technologies. (Zeihl, 2002) One can assume the expected changes in the population structure have not yet manifested. Empirical findings show an increase in orphans as a result of AIDS mortality and that fewer adults are responsible for more children. (UNICEF, 2005) This suggests high neontic dependency ratios. In fact Harvey (2003, p. 15) and Andrews et al. (2006, p. 273)

argue that because AIDS affects those in the prime productive and reproductive age groups, it seems more likely that it would have an impact on dependency ratios. This view is supported by Barnett and Whiteside (2002, p. 196) who argue that illness and death change the household age structure, as the middle layer of economically most active members of the household become ill and die. AIDS increases the dependency burden as it cuts away the middle generation that supports the young and the elderly. Evidence from the Rukai district in Uganda suggests that the household dependency ratio may increase from 1:2 to 1:5. (Harvey, 2003, p. 15)

In addition to non productive adults, dependency ratios are further increased by aged parents who rely on working children for their security. The dependency burden could be carried by the individual households or could be distributed across a number of households within the kinship network or in the community. De Waal & Tumushabe (2003, p. 6) and De Waal & Whiteside (2003, p. 5) introduce a new concept of dependency disjuncture to capture the different categories of dependents. If these different categories of dependents are included in the calculation of dependency ratios, it brings us closer to the effective dependency ratios.

#### **4.7.7 Effects on household income and expenditure patterns**

HIV and AIDS can lead to a rapid transition from relative wealth to relative poverty. Barnett & Whiteside (2006, p. 204) cite figures from studies in Zambia where disposable income dropped by 80% as a result of the death of male household heads. Harvey (2003, p. 18) cites figures from Malawi that show that HIV-related mortality can result in up to 65% loss of income in affected households. Andrews et al. (2006, p. 272) cite a study from Welkom in South Africa where income in HIV/AIDS affected households was less than half of non affected households.



Income loss includes reductions in household food production, reductions in the sale of agricultural produce and crafts, loss in wages or loss in remittances from household members or members from the family or kinship group. (Jackson, 2002, p. 25) The dearth of studies on the impact of HIV and AIDS on urban households makes it difficult to assess. Von Liere (2002, p. 6) shows that there are significant differences between the economic position of households affected by HIV and those that are not affected. These differences relate to changes in income, consumption and savings. He further argues that the reduction in income could lead to difficulties in accessing credit, as HIV/AIDS affected households may be stigmatised and be regarded as a risk.

AIDS mortality could have different impacts on different households. Some families may sell assets like livestock and draught animals to pay for increased expenditure related to illness and death. (Harvey, 2003, p. 23; Barnett & Whiteside, 2006, p. 204; Andrews et al., 2006, p. 272). In certain instances people sell seeds, surplus food as well as land to compensate for their income losses. The sale of productive assets could lead to a further downward spiral in household income since these assets are normally used to generate further income. (De Waal & Tumushabe, 2003, p. 7) Households may also sell other items like radios, television sets, furniture, jewellery and clothing in desperate attempts to obtain income. (Barnett & Whiteside, 2006, p. 205; Harvey, 2003, p. 17)

De Waal & Tumushabe (2003, p. 7) report that AIDS related mortality could also lead to the diversification of household income-generating activities, as rural households that primarily relied on agriculture could shift to off-farm, less labour-intensive market activities. In other households it could lead to the withdrawal from market-based activities in favour of pure

household-based subsistence economic activities. Yamane et al., as cited by Harvey (2003, p.17), report a 35-40% decline in off-farm income in AIDS-affected households compared to 12% in non AIDS-affected households, because people are less able to engage in casual labour and marketing activities as a result of illness and death. The loss of non farm incomes could affect female-headed households more, as Mutangadura & Webb (1999) report that in certain parts of Zambia there is a greater reliance on market activities and informal business in female-headed households. De Waal & Tumushabe (2003, p. 7) further point out that AIDS-related death in richer rural households could affect the income of other non AIDS-affected poorer households who rely on employment and therefore wages from the richer households. A study in Kenya by the same researchers showed that the death of a person in a rich household can lead to a loss of income in three poorer households as a result of a drop in employment opportunities and other intra-household transfers.

While firms and the state make contributions towards health care and medical expenses, the burden of home-based care and funeral costs are carried by households. (Barnett & Whiteside, 2006, p. 204) Morbidity and mortality also increase household expenditure due to increased medical expenditure, which includes medication, nutritional supplements and transport to medical facilities. Harvey (2003, p. 36), Van Liere (2002, p. 6, and Andrews et al. 2006, p. 272) cite a study in the Ivory Coast that showed a fourfold increase in medical expenditure by affected households. Barnett and Whiteside (2006, p. 204) argue that funeral expenses can outstrip medical expenses by 50%.

#### **4.7.8 Effects on household food security**

There are multiple connections between HIV/ AIDS and nutrition. As previously stated low nutritional status increases susceptibility to HIV infection. People who are mal- or undernourished are more likely to be infected by the virus than others, because they have lower biological resistance to HIV infection. Persons with low nutritional levels also become more infectious to others. (Jackson, 2002, p.102; Van Liere, 2002, p.3) Micro-nutrient deficiencies increase the likelihood of mother to child transmission. (Harvey, 2003, p. 33) HIV infected persons with low nutritional status also risk a more rapid onset of illness and death. The transition from the asymptomatic to symptomatic phase is faster in malnourished than in well nourished persons. Malnourished people are more susceptible to other secondary infections. (Van Liere, 2002, p. 3) PLWA are more at risk of malnutrition due to the following factors: (Harvey, 2003)

- Reduced food intake as a result of appetite loss or as a result of infections, mouth sores, fever or depression
- Poor absorption of nutrients like protein, carbohydrates, vitamins, fats, minerals and water
- Changes in the metabolism because problems with digestion may lead to the inefficient use of nutrients.
- Chronic fevers and infections requiring more nutrients, but because of the poor use of nutrients, malnutrition and weight loss occurs.

HIV and AIDS affect agriculture more than other sectors. Particularly the subsistence farming sector is less able to absorb the impact of AIDS. In sub-Saharan Africa more people rely on labour-intensive, subsistence agriculture for their livelihoods. (De Waal & Tumushabe 2003, p. 2)

2) Reciprocal relationships between HIV/AIDS and nutrition have resulted in De Waal & Whiteside's (2003) New Variant Famine hypothesis. They argue that HIV creates a new category of vulnerable households. Southern Africa has not seen comparable levels of famine, with comparable levels of orphaning. In other famines rural people were able to reduce food consumption and still show the physical capability to work. With the AIDS epidemic more households have chronically ill adults, and malnourished persons are more prone to illness and infection. Malnourishment suppresses the immune system. This makes the infections more virulent and hastens the progression from HIV to AIDS, which in turn impacts labour supply and food production. This creates a cycle of famine, while adequate nutrition is important to effective antiretroviral treatment.

Food insecurity undermines women's autonomy and contributes towards risky behaviour, as women are primarily responsible for household food supply and are therefore at times obliged to trade sex for food or cash. Food insecurity also increases the incidence of migration which means further risks of HIV transmission. (Harvey, 2003, pp. 33-34)

The absorption of OVCs by the extended family is not always benevolent. AIDS deaths generally lead to declines in household labour supply. There are instances where the adoption of OVCs is a strategy to compensate labour shortfalls. Boys are used for agricultural labour. (Harvey, 2003, p. 16) Girls are used as a source of income and may therefore be married off in order to generate bridewealth/dowries. (De Waal & Tumushabe, 2003, p. 10; Harvey, 2003, p. 16)

Girls may also be withdrawn from school to compensate for the loss of female labour in the domestic sphere such as child rearing, cooking and cleaning. However the adoption of OVCs can never completely offset the total loss in labour due to adult morbidity and mortality. Mutangadura (2005, p. 8) and Harvey (2003, p. 13) cite the Yamane et al. (2000) Kenyan study that shows between 48-68 percentage drop in output as a result of death in the household. Kwaraba's (1997) study in Zimbabwe shows 61 percentage reductions in maize output and 29 percentage reductions in cattle production respectively.

Rural women, particularly those in female-headed households (FHH) are responsible for household food supply as a result of the gendered division of labour and land allocation. The death of a female adult results in bigger decreases in grain production since women provide the bigger labour input into crop production. Harvey (2003, p. 26) and De Waal & Tumushabe (2003, p. 6) call this a double loss. In addition healthier women reduce time on food production in order to care for those who are sick or left vulnerable like orphans. The problem is further compounded by the fact that women tend to be infected at a younger age than men. Unless there is a redivision of labour, the burden will rest on fewer mature females. (De Waal & Whiteside, 2003, p. 5) Households may lose up to two person years of labour before the death of an HIV-infected person. The loss of labour, as a result of illness/inability to work, time used to care for sick persons and time taken to attend funerals, severely hampers output. A study in Uganda showed that women in AIDS-affected households spent zero time in the fields compared to the 60 hours of women in unaffected households. (Van Liere, 2002, p. 5) Jackson (2005, p. 336) therefore argues that to help infected persons in rural areas survive longer is not simply a humanitarian question, it also has economic and developmental implications.

De Waal (2003, p. 9) cites the following projections for labour reductions in some of the worst affected southern African countries:

**Table 6: Projections of labour reduction in southern Africa**

Country	Reductions by 2005	Reductions by 2020
Botswana	-17.2	130.8
Lesotho	-4.8	10.6
Malawi	-10.7	-16.0
Mozambique	-9.0	-24.9
Namibia	-12.8	-35.1
South Africa	-10.8	-24.9
Tanzania	-9.1	-14.6
Zimbabwe	-19.7	29.4

*(Source: De Waal, 2003, p. 9)*

Numerous authors (Harvey, 2003, p 14; De Waal & Tumushabe, 2003, p. 7; Barnett & Whiteside, 2006, pp. 244-258) have identified the effects of HIV/AIDS on agricultural production, namely:

- **Declining yields** as a result of labour shortages (Harvey, 2003, p. 14). In addition a smaller range of crops are grown on a smaller area. Farm work is disrupted as a result of funeral attendance resulting in a loss of productivity. Labour shortages also result in the neglect of agricultural infrastructure like irrigation and drainage channels, terraces, soil maintenance, clearing of land, fencing and storage facilities. (Barnett & Whiteside, 2006, p. 247) These factors impact on both household food security and the production and trading of surpluses.
- **Declines in crop variety and changes in cropping patterns** by switching to less labour-intensive crops that contain lower nutritional values. (Harvey, 2003. p. 14) Barnett & Whiteside (2006, p. 256) cite a study in Uganda that showed a decrease in labour supply resulting in crop switching from bananas and vegetables to cassava. De Waal & Whiteside

(2003, p. 4) cite a study in Malawi that reports a switch from highly nutritious cereals and oilseeds to less nutritious cassava.

- **Declines in livestock production** as households sell livestock to meet additional costs of illness and death. (Harvey, 2003, p. 14; Barnett & Whiteside, 2006, p. 257) Child labour results in less punctilious animal husbandry. Animals straying also results in stock losses. Inexperienced children are less able to identify good pasture or walk long distances to find good grazing. (Barnett & Whiteside, 2006, p. 247)
- **Changes in livestock farming:** Some families sell livestock in order to cover medical or funeral expenses. (Harvey 2003, p. 23) Others switch to less labour-intensive pig and poultry farming. (De Waal and Tumushabe, 2003, p. 7)
- **Decline in agricultural extension services** as more civil servants succumb to AIDS.

#### 4.7.9 Effects on intergenerational transfers

HIV/AIDS affects the economically productive sections of the population and changes the age structure in affected households. Often grandparents take over the care burden when illness and death deplete this middle layer (economically productive parents). This disrupts traditional welfare systems, where children provide for parents in their old age. The loss of economically active members of households increases the levels of poverty in these households. Poverty is then passed on to the following generation who will most likely engage in risky sexual behaviour as a result of poverty.

There is also a loss of intergenerational knowledge transfers particularly on coping strategies that can ensure the reproduction of the family unit. The intergenerational transfer of

agricultural skills is disrupted as a result of premature adult deaths. (Harvey, 2003, p. 14) De Waal & Tumushabe (2003, p. 6) further argue that this loss in skills, and the break in intergenerational knowledge transfers, can have a severe impact on the viability of the households, for knowledge of farming, marketing, access to credit or responding to adversity is not easily replaced. The human capital loss as a result of AIDS mortality includes loss of knowledge of land preparation, crop production, livestock production and marketing skills. (Harvey, 2003, p.17)

#### **4.7.10 Coping and Survival Strategies**

There is a debate about whether households affected by AIDS are coping or surviving. De Waal & Tumushabe (2003, p. 3) argue that the word “coping” is a misnomer since AIDS-affected households can seldom maintain or preserve a socially acceptable level of living. Mutangadura & Webb (1999, p. 9) prefer the more neutral term of loss management with reference to the changes households make to mitigate the impact of AIDS.

When traditional social security networks are invoked to mitigate the impact of AIDS, the sheer magnitude of the problem still results in the social rupture of traditional systems to the point of breakdown. (Abebe: 2005) This may explain the Child Headed Household, street-child and child-gang phenomena associated with rising AIDS mortality. Mutangadura & Webb (1999, p. 9) identified the three following stages in impact mitigation strategies of rural households in Zambia’s Kafue district:



**Table 7: Stages of household loss management**

<b>Stage1:</b> Reversible strategies that have no or little impact on future earning and productive capacity	<ul style="list-style-type: none"> <li>-Seeking wage labour</li> <li>-Temporary migration</li> <li>-Switching to low maintenance subsistence crops</li> <li>-Liquidating saving accounts.</li> <li>-Selling property</li> <li>-Tapping obligations from extended family.</li> <li>-Borrowing</li> <li>-Reduced consumption</li> <li>-Decreased spending on education, non urgent health care and other human capital investment.</li> </ul>
<b>Stage2:</b> Disposal of productive assets that undermine future income and productive and productive capacity	<ul style="list-style-type: none"> <li>-Selling land, equipment and tools.</li> <li>-Borrowing at enormous interest rates.</li> <li>-Further reductions in consumption, health and educational expenditure.</li> <li>-Reduction of land farmed and types of crops produced.</li> </ul>
<b>Stage3:</b> Destitution, few coping strategies available	<ul style="list-style-type: none"> <li>-Dependence on charity</li> <li>- Dissolution of households</li> <li>Distress migration</li> </ul>

(Source: Mutangadura and Webb, 1999, p. 9)

## 4.8 Care and Support for OVCs

According to Andrews et al. (2006, pp. 274-275), Barnett & Whiteside (2006, pp. 210-235), UNICEF (1999, pp. 3-6), and Sarker et al. (2005, p. 213), OVCs are thus more likely to:

- Face stigma and isolation because of the HIV positive status of caregivers/parents
- Face stunted growth as a result of nutritional deficiencies
- Not be enrolled in or drop out of schools because they cannot pay school fees. They have to engage in income generating activities, replace adult labour or they become caregivers themselves by having to care for sick adults or younger children. Girls are more likely to drop out than boys in order to assume care taking responsibilities.
- Lack parental supervision, and be placed by poverty at risk of sexual exploitation and possible HIV exposure
- Become involved in criminal activities due to lack of parental supervision
- Be deprived of their inheritance upon the death of parents
- Be less likely to access health services like immunisation or visits to health facilities
- Lack access to legal services
- Face emotional problems as a result of illness and death of parents and caregivers as well as from their insecure livelihoods

The literature hails family and community level coping strategies. The Social Capital framework that encourages communities and families to take on the burden of care and impact mitigation seems to find resonance with governments and international institutions like the World Bank and is part of the neo-liberal worldview that absolves the state from its social responsibilities towards poorer sections of the citizenry, since the ideology of a minimalist state supports the neoliberal regime of fiscal discipline and cuts in social spending. However Barnett & Whiteside (2006, p. 350) point to how the literature uses the word “coping” as a justification for inequalities and deprivation by lowering the bar for what is regarded as acceptable living standards by those

made vulnerable by HIV/AIDS. They further argue that the term “coping” is once again a way of disenfranchising the poor further, by denying them entitlements normally associated with acceptable human life.

As a result of denial, lack of vision, leadership and capacity, many governments were slow in responding to the emerging orphan crises. In addition, traditional African social security networks around the extended family relieved governments of their responsibilities towards vulnerable children. In terms of the Conventions on the Rights of the Child, governments are responsible for pursuing the best interest of the child, for ensuring the right to survival, well being, development and creating a climate of non discrimination. (UNICEF 2003, p. 37)

Households that take in orphans are in all likelihood already poor, as AIDS related illness may already have depleted resources. Increased dependency ratios will exacerbate this poverty. UNICEF (2003, p.18) Jackson (2002) and UNICEF (2003) point to the responsibilities taken on within the extended family system with regard to OVC care. The care burden may be taken over by the surviving parent, grandparents, aunts, uncles, older siblings or other members of the extended family. Those who cannot be absorbed into the extended family network may be fostered or adopted outside the family or end up in institutional care. There are, however, some who end up on the streets and end up being exploited, or they may participate in criminal activities.

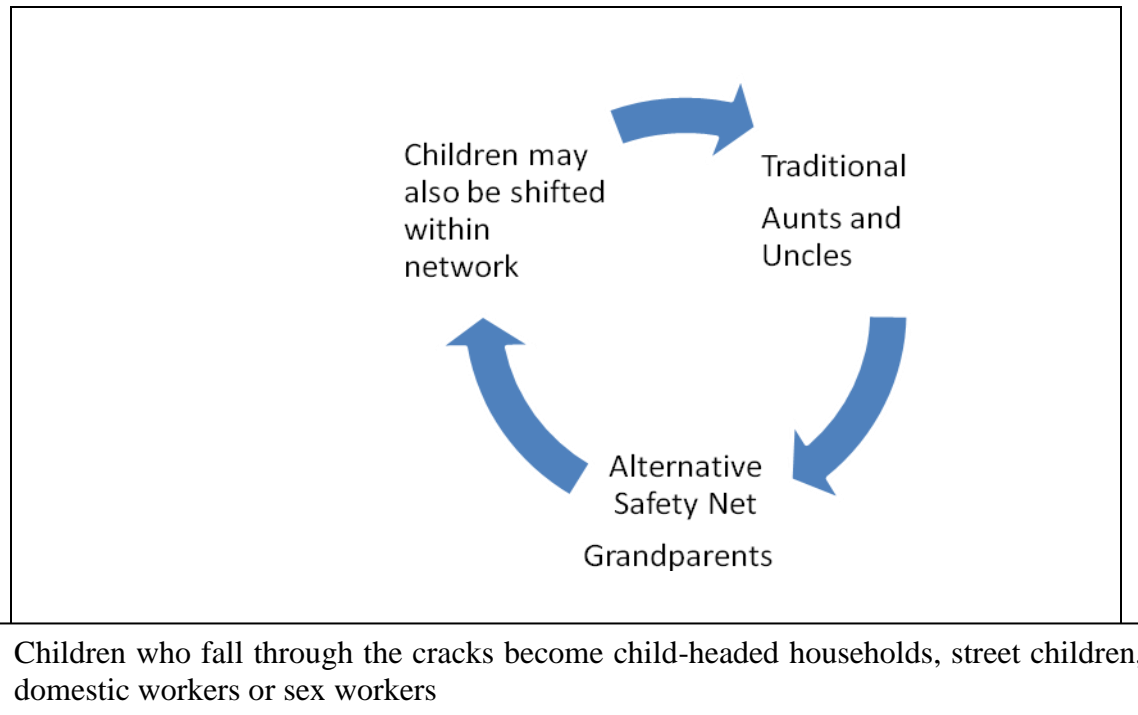
In 2001 the United Nations General Assembly Special Session on HIV/AIDS adopted a Declaration of Commitment with regard to OVCs. The goals set out in the Declaration include: (UNICEF, 2003, p. 37)

- Strengthening the capacity of families to protect OVCs
- Mobilising and strengthening community based responses
- Ensuring access to essential services for OVCs
- Ensuring that governments protect OVCs
- Raising awareness towards creating a supportive environment for OVCs

A number of countries have developed support programmes that include child support grants, payment of school and medical fees, free access to services, improvement of economic capacity through small business development projects, agricultural projects, and access to labour saving technology and access to skills training.

There seems to be general agreement that the extended family care system is culturally the most preferred and often in the best interest of the child. However, there are also widely reported instances of abuse and neglect within the system. Ntozi (1997) cites studies in West and East Africa that show a tendency to abuse foster children, particularly when they are not kin. In Sierra Leone foster children experienced higher levels of under-nourishment and higher mortality. In the Rukai district of Uganda neglect was related to the age of caregivers, who were mainly over fifty and did not have the energy or resources to care for the children.

**Graph 3: OVC Care Network Cycle**



The decisions about who should care for orphans are often made by members of the clan, grandparents, the dying parents, or orphans themselves. Ntozi (1997) reports that in certain parts of Uganda clan members are more involved in deciding the care arrangements for paternal orphans, whereas grandparents often decide about the care arrangements for maternal orphans. The traditional role of grandparents as heads of families even when their children are alive also contributes towards their decision-making status. Paternal orphans who reside with their surviving mothers experience more financial strain, but also a greater degree of parental care than other orphans. Those in the care of NGOs and friends may experience fewer financial problems, but lack parental care. Ntozi further cites other studies that show that surviving fathers are not good caregivers. This may explain why grandparents often take on the burden of care. In certain instances grandparents are assisted by other relatives or older siblings.

Some of the community-based initiatives include: (UNICEF, 2003, pp. 39-45; Jackson, 2002, pp. 276-291)

- Home visit programmes
- Informal fostering and formal adoption services
- Counselling and referral services
- Day-care programmes
- Pooling funds to provide material assistance to struggling families
- School feeding programmes and soup kitchens
- Birth registration so that children can access government services
- Legal services to protect children's rights, particularly inheritance rights
- Succession Planning and Memory Book projects

In Africa there is a general aversion to institutional care arrangements. This is as a result of cultural and economic factors. In addition to the negative effects of separating family members and stigmatisation, institutional care is regarded as more expensive and less effective than family and community-based arrangements. There is also some suspicion that some of the institutional arrangements have sprung up to cash in on donor funds, and hence are motivated by self-interests rather than benevolence. Some also point to the abuses that often occur in the institutional environment. (Jackson, 2002, p. 286) It is nonetheless the responsibility of the state to provide institutional care for children who cannot be accommodated through other care arrangements.

Some argue that uncared for bands of unsupervised street children may hold a security threat. (Harvey, 2003) Pharaoh & Schoenteich (2003) caution that as mortality rates increase in

southern African societies, we can expect increases in the number of children without parental protection. These socially excluded juveniles could be drawn to crime which could decrease safety and security in the region. It may therefore be in the interest of governance to deal with the orphan crises. In addition there are various international and national instruments that protect children's rights and oblige governments and society as a whole to develop policies and programmes that provide care and protection to OVCs.

## **Chapter 5: The effects of HIV and AIDS on families: A review of the Namibian literature**

This chapter reviews the relevant HIV and AIDS Namibian-based literature. It covers a situational analysis of HIV/AIDS in Namibia and then specifically looks at the effects of morbidity and mortality on families and children.

### **4.1 Introduction**

Namibia is ranked amongst the top five AIDS affected countries in the world. (Global Fund Secretariat, 2002) The unpublished 2008 sentinel survey statistics are reported to show a decrease in HIV prevalence rates compared to 2006 statistics. In 2006 the national HIV prevalence rate was 19.9 percent. In 2008 it stood at 17, 8 percent. (Republic of Namibia, 2007 a) This shows a marked improvement since 2002 when national prevalence was 22 percent. The Minister of Health attributed the decline in HIV prevalence to a number of measures, including the adoption of protective behaviour measures. The greatest declines in prevalence rates were in the 15-19 year age group, which is down to 5, 1 percent from 10, and 4 percent in 2006. (Maletsky, 2008 c) There are, however, still great regional disparities and prevalence rates. Katima Mulilo shows a decline of over 11 percent since 2002, but is still very high at 31, 7 percent (Maletsky, 2008 c) compared to places like Opuwo. The 2006 National HIV Sentinel Survey Report shows increases in the prevalence rates amongst the 30-34 year age group (29.5 percent). This figure is now down to 27, 1 percent, which is still very high. (Republic of Namibia, 2007a)



**Table 8: HIV AND AIDS ESTIMATES: Namibia**

Number of people living with HIV: 200 000 [160 000 - 230 000]

Adults aged 15 to 49 prevalence rate: 15.3% [12.4% - 18.1%]

Adults aged 15 and up living with HIV: 180 000 [150 000 - 220 000]

Women aged 15 and up living with HIV: 110 000 [88 000 - 130 000]

Children aged 0 to 14 living with HIV: 14 000 [12 000 - 16 000]

Deaths due to AIDS: 5 100 [3 100 - 7 100]

Orphans due to AIDS aged 0 to 17: 66 000 [50 000 - 85 000]

*(Source: Epidemiological Fact Sheet on HIV and AIDS, 2008)*

**Table 9: HIV prevalence rates in Namibia**

Age Group	Number Tested	Number Positive	Percent Positive
15-19	1397	142	10.2
20-24	2482	407	16.4
25-29	1569	422	26.9
30-34	1044	308	29.5
35-39	577	139	24.1
40-44	201	34	16.9
45-49	33	3	9.1
<b>Total</b>	<b>7303</b>	<b>1455</b>	<b>19.9</b>

*(Source: Report of the 2006 National HIV Sentinel Survey: Republic of Namibia 2007 a)*

It is also important to note that despite the decline in HIV prevalence, there are still high rates of new infections. It is estimated that there are 44 new infections per day. In 2007 there were 7000 new HIV infections of which 5200 were women. This rate of new

infections will make treatment, at its present cost, unsustainable in the long-run. (Hanime, 2008)

Whiteside & Sunter (2000) distinguished between different phases of the HIV epidemic depending on the extent to which it has spread within a population.

- *Nascent*: < 5% in all sub-populations known to be practising high-risk behaviour
- *Concentrated*: >5% prevalence in one or more high-risk sub populations
- *Generalised*: The epidemic has spread beyond the initial high-risk groups to the general population and >5% prevalence rate amongst women attending antenatal clinics

According to the above criteria it could be argued that Namibia has a generalised epidemic. However, it is also recognised that there are different structural drivers that make different groups in the population susceptible to HIV infection. In North America and Europe risk groups were often identified as MSM, intravenous drug users and prostitutes. In Namibia there are also other risk groups that make up large parts of the general population, like hetero-sexual men and women involved in multiple and concurrent sexual relationships. This includes married women in stable sexual unions or young women involved in different types of inter-generational sex. It is for this reason that the notion of multiple and concurrent epidemics is more illuminating than the concept of one generalised epidemic.

According to The Rainbow Project (trp), a sexual minorities rights organisation, there is a general HIV epidemic with vertical hetero-sexual transmission, but there is also a concentrated epidemic amongst MSM that is pegged at around 15,2 percent. The MSM HIV/AIDS epidemic

has been dubbed the undocumented epidemic because of the homophobia and homosexuality denialism in Namibia. Research that was done by the trp and others shows that MSM face stigma and discrimination and are therefore less likely to access health care services. (Sasman, 2008)

**Table 10: HIV prevalence in Africa**

Nascent	Concentrated	Generalised
Algeria	Angola	Botswana
Cape Verde	Arab Republic of Egypt	Burkina Faso
Comoros	Benin	Burundi
Djibouti	Cameroon	Central African Republic
Madagascar	Chad	Guinea-Bissau
Mauritania	Dem. Rep. of Congo	Ivory Coast
Mauritanians	Ethiopia	Kenya
Morocco	Eritrea	Lesotho
Somalia	Gabon	Malawi
Seychelles	Gambia	Mozambique
	Ghana	<b>Namibia</b>
	Guinea	Rep. of Congo
	Mali	South Africa
	Niger	Swaziland
	Nigeria	Tanzania
	Rep. of Congo	Togo
		Uganda
		Zambia
		Zimbabwe

(Source: Whiteside & Sunter, 2000)

Women bear the greatest HIV burden. They account for 62 percent of HIV infections and 55 percent of those living with AIDS. (Ngavirue, 2006) A Centre for AIDS Development, Research and Evaluation (CADRE) survey revealed that young women are more at risk, because they are more likely to be involved in intergenerational sex and therefore face greater HIV exposure than if their sexual partners had been in their age range. (Tjatindi, 2008)

The MoHSS Essential Indicator Report (Republic of Namibia, 2003c) shows AIDS to be a leading cause of death for adults in the productive and reproductive age-groups in the different regions of Namibia.

**Table 11: Namibia-Causes of Death in 18-49 year old per 10000 population by region**

Cause	CAP	ERO	HAR	KAR	KAV	KHO	KUN	OHA	OMH	OMU	OSHI	O'KO	OTJ
AIDS	28	67	51	35	126	271	30	245	26	417	77	113	14
Pulmonary TB	48	39	51	33	94	169	4	107	30	151	124	163	12
Diarrhoea/gastro	92		12	12	129			45		92	204	249	20
Malaria	39	4			69		19	189	5	140	130	155	
Pneumonia		7	22	16	67	63	5	139		44	119		17
Other respiratory	28											44	
Injury / fracture						40							
Meningococ						20							
Heart failure			5						6				

(Source: Essential Indicator Report 2001-2002: Republic of Namibia, 2003c)

Regions: CAP=Caprivi; ERO=Erongo; HAR= Hardap; KAR=Karas; KAV=Kavango; KHO=Komas;

KUN=Kunene; OHA=Ohangwena; OMH=Omaheke; OMU=Omusati;

OSH=Oshana; O'ko=Oshikoto; OTJ= Otjozondjupa

## 5.2 Treatment Access

Up until March 2008, an estimated 230 0000 Namibians had been infected **by** HIV, and an estimated 100 000 had already died of AIDS. The Minister of Health warned that the 230 000 cited as HIV+ persons may just be the tip of the iceberg. (Namibia Today, October 12, 2007) By May

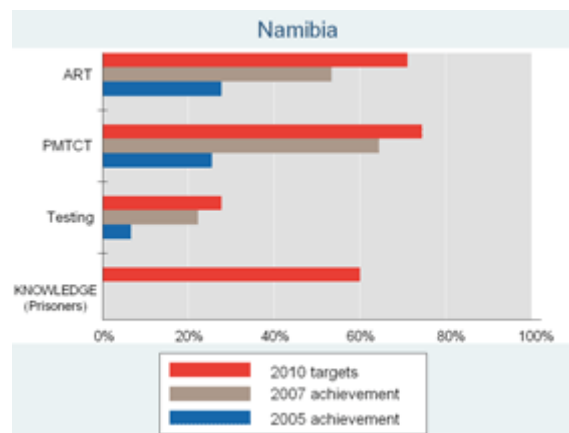
2008 the number of those on treatment in the public health system was 47 800. An estimated 8000-9000 people were receiving ARV treatment through private medical practitioners. Women account for 66% of those on treatment, and children account for between 12-15%. (Hanime, 2008) Men account for the smallest portion of those receiving treatment as a result of their reluctance to go for voluntary testing. (New Era, February 14, 2008) This is corroborated by the Ibis-Lironga Eparu-The Rainbow Project (2007) study that found that 78% women compared to 61% men were on ARV treatment. It also supports the theory that women are more likely to go for testing earlier than men.

During the 1990s the Namibian government provided ARV treatment in specific cases. It was however only after NGO pressure, particularly from the Legal Assistance Centre's (LAC) Treatment Action Forum, that government started indicating its willingness to roll-out ARVs to all who need it. (Hopwood, Hunter and Kellner, 2008) State sponsored ARV treatment programmes started at six pilot sites in 2003. By May 2008 the health ministry managed to roll it out to all 34 district hospitals and 17 satellite sites in the country. (Hanime, 2008) The country has so far achieved an over 90 percent success rate with treatment regimes for those who have been able to access treatment. According to the Ibis-Lironga Eparu-The Rainbow Project Report (2007, p. 17) just above 30 percent of people in need of ARV treatment were receiving it nationally. However the UNAIDS report on treatment access progress hailed Namibia as a best practice example, where 88% of people who need it have access to ARV treatment. (The Namibian, June 12, 2008) It is difficult to explain the incongruence between the statistics cited by these different sources. If one is to accept the official statistics, there is still a treatment gap of around 12%. Specialised ARV treatment clinics are attached to district hospitals and are run by the American Centre for Disease Control (CDC).

A small percentage of patients treated have shown drug resistance and therefore had to be treated with more expensive, second line drugs. The Minister of Health and Social Services reports a 76% treatment success rate, 5% mortality rate and 2% treatment default rate on its ARV roll out programme. A further 21% could not be traced mainly due to high levels of mobility and migration as a result of high unemployment and other factors. This could pose a risk of drug resistance both for HIV and TB because of the high rate of co-infection between the two (Hanime, 2008). To reduce default rates treatment support groups were established to provide those seeking treatment with a supporter to increase compliance with treatment regimes. The notion of “expert patients” amongst PLWA was also raised. These “expert patients” would be based at health care facilities and would take on some of the counselling, knowledge and information sharing activities to ease the burden on health care workers. (Ibis-Lironga Eparu-The Rainbow Project, 2007)

Graph 4 below shows Namibia’s progress with regard to universal ARV treatment access.

#### **Graph 4: UNIVERSAL ACCESS**



(Source: *Progress towards Universal Access - Fact Sheet, 2008*)

In 2007 the MoHSS issued the following guidelines for selecting antiretroviral treatment for adults and adolescents: (Ibis-Lironga Eparu (LE)-The Rainbow Project (trp), 2007 and Republic of Namibia 2007b)

- WHO Clinical Stage 3 or 4 HIV disease irrespective of CD4 count or
- CD4 cell counts <200 cell/mm<sup>3</sup> /or < 250/mm<sup>3</sup> for pregnant women irrespective of WHO clinical stage
- People who meet the following social eligibility criteria, namely people who have lived at a fixed address for the past three months; have access to a designated treatment centre for follow-up; do not drink alcohol; have no untreated, underlying psychiatric disorders and who are committed to strict life-long adherence to HAART, who are practising safe sex and will allow home visits.

The Ibis-LE-trp survey (2007) concluded that in the main the government's ARV roll-out policy has been effective, as 64% of LE members who were on ARV treatment had a CD4 count below 200 at the time of diagnosis, but due to treatment the figure dropped to 24% at the time the research was done in 2005. Despite the successes there are still impediments to treatment access. The Ibis-LE-trp treatment survey (2007) recorded the following impediments:

- People had to go on waiting lists before they could access treatment, at times waiting up to a month before they could access treatment.
- Lack of viral load testing to monitor the progression of HIV and treatment adherence
- Lack of treatment literacy and lack of information amongst patients and health care workers (HCW) about viral load testing, treatment side effects and treatment regimes

- Fear of stigma or others knowing their HIV status prevented around 7% from accessing treatment.
- Some (21% of LE members) reported being treated badly, unfairly or being subjected to stigma-related behaviour.
- Majority (89%) of those who were very poor experienced difficulty in seeing a doctor.
- Strong correlation between poverty and defaulting treatment. Some (33%) of those who reported side effects of treatment said that the treatment made them too hungry, and that they could not afford the food to sustain the treatment regime.
- Twenty percent of patients stopped treatment as a result of side effects, often because they did not receive proper counselling about these side effects or see a HCW who could advise them otherwise.
- Travel distance to ARV clinics or dispensaries for fill-ups. The study found a higher level of treatment default or inconsistent usage by those who were more than 10km away from the ARV clinic.
- Long waiting periods at health care facilities
- Only half of the pregnant women or women who were pregnant and HIV positive participated in a prevention of mother-to-child transmission (PMTCT) programme. This is far higher than the general population (i.e. not the research population) which UNAIDS (2008) sets at 25%.

In June 2008 the MoHSS announced certain exemptions from health care charges for pensioners, people with disabilities and OVCs. Although this was done to facilitate access to



health services, it does not make specific provision for PLWA who, as the IBIS-LE-trp (2007) report indicates, are often unemployed and poor. (Sibeene, 2008b)

There is also the question of confidentiality linked to the Ministry of Health and Social Services requirement that those seeking ARV treatment should have a treatment supporter. A treatment supporter could be a friend or relative who encourages the treatment seeker to abstain from sex, or encourages condom use and keeping doctors' appointments, reminds them to take their medication, and informs health workers if they engage in behaviour that will affect their health negatively, like abusing drugs or alcohol. While the Minister of Health, Richard Kamwi, has argued that this was necessary for treatment adherence, the human rights organisation, Legal Assistance Centre (LAC) argues that this requirement may prevent people from seeking treatment because they may fear stigma, discrimination, exclusion or a breakdown in confidentiality. (Sibeene, 2007c) This debate once again highlights some of the conflicting policy directions on HIV/AIDS. While the Minister argues from a public health perspective, the LAC emphasises the human rights aspect of HIV treatment.

The joint Ibis-Lironga Eparu-The Rainbow Project (2007) research on HIV and AIDS Treatment amongst PLWA found 91 % treatment adherence amongst Lironga Eparu members. The survey found that the biggest impediments to adherence were factors related to poverty and treatment side effects. The survey found that those who did experience side effects were also more likely to experience poverty and therefore had nutritional deficits.

Despite the high adherence rates, 42% had trouble staying on ARV mainly because of the lack of food and transport to medical facilities and a lack of social support. In fact the survey

found that 19% of those who earned less than N\$500 a month stopped taking treatment compared to 12% of those who earned between N\$500-N\$1500 per month, which shows a positive correlation between levels of poverty and treatment adherence.

By March 2008 the country was dedicating 10% of its budget to health care, and a large portion of this was dedicated to the prevention, care and treatment of HIV/AIDS. (Hanime, 2008) This is still insufficient since planners predict that Namibia will require around 12-15% of government expenditure for its HIV/AIDS response. (Maletsky, 2008a) A large part of the resources dedicated to the fight against HIV and AIDs in Namibia comes from external sources. In 2005 63% came from foreign donors. (Maletsky, 2008a) Most of the treatment funds come from the Global Fund against Tuberculosis, Malaria and AIDS and the US governments President's Emergency Plan for AIDS Relief (PEPFAR). There is still a danger that drug resistant strains of the HIV virus could spread further amongst the population. This would make treatment more expensive and in certain cases even impossible. (Weidlich, 2006; Maletsky, 2006 a)

There are other service delivery bottle-necks that are affecting PLWA. In a briefing to the Parliamentary Standing Committee on Human Resources, Social and Community Development in August 2007 social workers cited lack of personnel, transport, equipment and bureaucratic red tape as key impediments to ensuring service delivery. (Ngavirue, 2007c) The Ibis-Lironga Eparu-The Rainbow Project Report (2007) showed that in certain places in Caprivi, patients were requested to provide identity documents or birth certificates before they could access ARV treatment. People often do not have these documents, because births were not registered, or due to the long waiting period for applications to be processed.

### 5.3 Poverty and HIV/AIDS in Namibia

High HIV prevalence and AIDS death rates come at a time of economic dislocation, mass poverty and high income disparities. (Global Fund Secretariat, 2002, p. 2) In addition to the high HIV infection rates, Namibia also has the world's second highest tuberculosis (TB) rates, with 765 cases per 100 000 people. Increasingly the country is also experiencing multi-drug resistant (MDR) and extensive drug resistant (XDR) TB. The TB-HIV co-infection rates stand at 59 percent. (Sibeene, 2008a)

The broader structural economic features that undermine health and provide conditions for rapid HIV spread are reflected in some of Namibia's key economic indicators like the Gini coefficient and the Human Development Index. (Republic of Namibia-National Planning Commission, 2008; United Nations, 2004) Although Namibia is classified as a lower middle income country, average per capita income masks the high levels of income inequalities. The Gini coefficient that measures income inequality currently stands at 0.63, which is one of the highest in the world. (Republic of Namibia, 2008) Caprivi and Ohangwena are Namibia's poorest regions in the country, and they also have the lowest level of per capita consumption <sup>xvi</sup> and the highest level of AIDS deaths and therefore high orphan populations. (Ruiz-Casares, 2007; Weidlich, 2006 b) In fact the Ibis-Lironga Eparu-The Rainbow Project (2007) found that 64 percent of the PLWA from the Lironga Eparu sample were unemployed, and 50%, mostly women, earned below N\$500 per month.

Rural households bear the brunt of the AIDS epidemic and have the lowest capacity to mitigate its impact. Average incomes in urban areas are four times higher than in rural areas.

(United Nations, 2004) While female-headed households are more likely to take in AIDS orphans, on average they have half the income of male headed households. Unemployment is at around 36 percent, and 38 percent of Namibian households live in relative poverty, and nine percent in extreme poverty, while between 60 and 80 percent of household income is spent on food respectively. A clear indication of gross inequality is the difference in Namibia's per capita GDP ranking which is 65<sup>th</sup> out of 175 countries compared and its Human Development Index ranking, which is 126<sup>th</sup>. (United Nations, 2004)

The linkages between poverty and AIDS are most acute in the subsistence farming areas from where 57, 8 percent of the Namibian population derive their main source of income. (Republic of Namibia-NPC-NHIES, 2003/2004) Research in southern Africa has shown that agricultural-based economies are less able to cope with the impact of HIV and AIDS. The United Nations has classified the combination of AIDS, food insecurity and lack of capacity as the Triple Threat to stability and as Namibia's impending humanitarian crisis. (United Nations, 2004)

The Global Fund Secretariat (2002, p. 30) predicts the following impacts of HIV/AIDS on the Namibian economy:

- Decrease in GDP per capita of 2.5 percent per annum up to 2010
- Declining health leading to reduced productivity
- A 20 percent increase in health expenditure
- Rising mortality leading to a 35 percent loss of the labour force, which increases the care burden and poverty in affected families
- Increase in vulnerable children in regions with the highest poverty indices

The United Nations (2004) points to the reciprocal relationship between AIDS and poverty and argues that AIDS increases income poverty of households and communities by threatening the most economically active adults and burdening households and communities with the costs of the care burden. Increased AIDS mortality has already resulted in demographic changes in Namibia's population structure. Namibia's life expectancy has dropped from 62, 8 and 59, 1 to 50 and 48, 8 years for women and men respectively between 1991 and 2001. (Maletsky, 2006b) AIDS accounts for 46 percent of deaths in the 15-49 age groups, which is economically the most productive section of the population. (United Nations, 2004, p. 20) This may have a negative impact on dependency ratios. Already 40 percent of the Namibian population is under the age of 15 years and half under the age of 20 years. (Ruiz-Casares, 2007, p. 148)

The high AIDS mortality rates affect the family and household structures. Sporton & Mosimane (2006) found that in the Omusati Region, Elderly Headed Households (EHH) often missed a middle generation. This means that they consist of aged grandparents (mainly women) and children.

Besides the declines in life expectancy, AIDS is also one of the factors that had a negative impact on population growth, which has declined from 3, 1 percent per annum to 2, 6 percent in a decade. (United Nations, 2004) This decline, however, does not off-set the high dependency ratios associated with Namibia's post independence baby boom.

The rural areas that are most affected by poverty and AIDS mortality also have the highest percentage of young people and senior citizens because of labour migration. This increases

dependency ratios in these areas. UNICEF (2007) estimates that around 150 000 children under the age of 17 have lost at least one or both parents to AIDS in Namibia, and Yates (2005) cites figures of 156 165 orphans between the 0-19 years, 90 000 under the age of 15 and 7 000 Child Headed Households. (Yates, 2005) It is estimated that these numbers will grow, and some even argue that orphanhood is a significant and an emerging state of being in many African societies. (Abebe, 2005, p. 38)

#### **5.4 Effects on household income and expenditure**

Le Beau and Mufune (2003, p. 350) found that families in the worst AIDS-affected areas of northern Namibia experienced:

- Increased expenditure on medical costs, food and nutrition to care for those who are sick
- Funeral cost for those who died
- Increased burden of care for the sick, orphaned and otherwise made vulnerable. The care burden rests mainly on women whose workloads increase.
- Many extended families having to care for multiple PLWA and their offspring.

The study also found that in poor households AIDS orphans may not find themselves in ideal care arrangements as they suffer food insecurity, drop out of school or do not gain access to services as a result of poverty within the extended family. This is corroborated by Thomas (2005) who points out that OVCs already come from families with a low resource base. She therefore argues that HIV/AIDS impacts should be understood in the context of multiple and co-existing vulnerabilities.

Haludilu (2005) found that although 81 percent of OVCs in Windhoek lived in households where one to two persons were employed, these households were nonetheless poor with monthly household income ranging between N\$200, 00-N\$ 1000, 00 since the employed were in low wage jobs like domestic work, security industry and cleaning services. In rural areas household incomes of HIV-affected households are even lower. Fuller & Van Zyl (2006, p. 212) found that non farm household incomes in rural areas in Namibia's northern regions were on average between N\$ 300 to N\$ 650 per month.

Besides loss of income as a result of illness and death, HIV-affected households also face increased expenditure as a result of illness or death. Thomas (2005) and Sporton & Mosimane (2006) found that particularly female and elderly-headed households that are faced with a lack of labour supply have to use cash income to employ others to do heavy duty labour like land clearing. Thomas also found that in Caprivi extended mourning periods and administrative delays in releasing bodies affect productivity, as relatives are prohibited from working during the mourning period. In addition they have increased funeral expenses, for beyond the coffins they also have to feed the mourners over extended mourning periods.

Social pensions often form the primary safety net. In fact the pension payment is often the only cash injection into the local economy and supports other economic activities in the informal economy. Sporton & Mosimane (2006) found that the old age pension has effectively become an AIDS grant. Fuller & Van Zyl (2006, p. 20) found that 59 percent of households cited government provided old age pensions as the main source of income.

In addition to old age pensions, the Namibian social security net allows for other welfare payments like state maintenance grants to biological parents if the breadwinner receives other forms of welfare payments, has died or is incarcerated for more than six months. The amount of N\$ 200 p/m is payable for the first child and N\$ 100 for every additional child (maximum 3 children). There is also a Special Maintenance Grant of N\$ 200 p/m for disabled children under the age of 16 and a Foster Care Grant for foster parents who obtained custody in terms of the Children's Act (No 33 of 1960), at the same rates as the Maintenance Grant. (Terry, 2007, p. 24) Despite this the Project HOPE (2006, p. 11) found a 90 percent income insufficiency in households that host OVCs, which indicates that government transfers in the form of grants and pensions are simply not sufficient to lift people out of poverty.

The World Food Programme (WFP) Community Household Surveillance (CHS) (2006) study found that only 11 percent of the 73 households sampled received cash grants. This demonstrates a low uptake of non pension grants. Sporton & Mosimane further found that between 73 percent of other households and 81 percent of elderly-headed households (EHH) did not receive any other form of assistance. Only between 4, 5 percent of EHH and 7, 5 percent of other households received child support grants. They concluded that the low uptake of child care and disability grants may reflect the cumbersome registration procedures. This is corroborated by the Namibia Red Cross (2006) study in Ohangwena Region, which identified delays in processing grant applications and the lack of birth certificates required for registration as the biggest impediments to accessing grants. Ngavirue (2007 a) reports a case of a household headed by a 14 year old girl who cares for five siblings and who could not access grants because she is legally a minor, and therefore could not obtain the identity documents required for an application. This was



despite the fact that she and her siblings had birth certificates and the mother's death certificate to prove their ages and orphan status.

The fact that disability grant applications require a doctor's certificate stating current incapacity may affect the disability grant applications of PLWA negatively. Persons may get the grants when they are symptomatic, but the moment they are on ARVs and their health improves, they stand to lose the benefit. A doctor's certificate must clearly state that the person has full blown AIDS, but once the person receives ARV treatment and the disease is regarded as in remission, the benefit will be withdrawn. (Sporton & Mosimane, 2006) This has led to calls for a permanent HIV grant for HIV+ persons or the implementation of a Basic Income Grant or other forms of social grants for PLWA. (Gaomas, 2007) It is also reported that widows refuse to submit copies of their husband's death certificates to children fathered out of wedlock, thus depriving these children of the opportunity to apply for grants. (Mbangula, 2006)

Bureaucratic impediments in accessing social transfers like maintenance and foster-care grants have prompted the Permanent Secretary of the Ministry of Gender Equality and Child Welfare to urge the Ministry of Home Affairs to expedite the processing of national documents, so that the 90 000 food insecure children, who by August 2007 were receiving short-term emergency food aid, could be transferred to the social welfare system. (Sibeene, 2007 b) Delays in processing social assistance applications are also caused by staff shortages. The MoHSS reported a number of vacant posts in May 2008. For example 256 medical officers', 270 registered nurses', and 127 social workers' posts were vacant. (Hanime, 2008)

The Project HOPE (2006), Sporton & Mosimane (2006), World Food Programme Community Household Surveillance Survey (WFP/CHS) (2006) and Fuller and Van Zyl (2006) all show that in the subsistence agricultural economies of northern Namibia most HIV and AIDS affected households rely on cropping and animal husbandry. Sporton & Mosimane report that 97 percent of households in their sample were engaged in cultivation as the main source of livelihood. This was followed by pensions and livestock rearing. They also report gender differences in livelihood sources. While 90 percent of male headed households owned cattle, only 28 percent of female-headed households had cattle. This could explain the differences in income and wealth between male and female headed households in these areas. WFP/CHS (2006) found that 80 percent of households had access to agricultural land and were involved in crop cultivation. The study reports the following livelihood sources for beneficiaries and non beneficiaries:

**Table 12: Main livelihood sources**

<b>Beneficiaries of Food Aid</b>	<b>Non beneficiaries</b>
Food assistance 58%	Food crop sales 49%
Food crop sales 48%	Pension 41%
Pension 43%	Casual Labour 18 %
Casual labour 19%	Formal salary/wages 16%

*(Source WFP CHS, 2006, p. 2)*

Fuller & Van Zyl (2006, p. 27) found that the sale of crop surpluses did not seem to contribute to increased cash income, as households normally store surpluses as a buffer against drought or barter it for other goods and services. In the few instances where surpluses were sold, it yielded a paltry sum of between N\$ 119.00 and N\$ 350.00 per year.

The question of remittances and intra-family transfers requires further investigation since the literature provides a rather contradictory picture. UNICEF (2002,p. 63) found that there was important networking amongst the extended family, and that care giving households received support from members of the extended family. This supports Edwards' (2004) findings that most male respondents reported cash transfers to relatives, and that most females reported receipt of cash transfers. Fuller & Van Zyl (2006, p. 21) also found that the loss in earnings due to HIV related illness or death leaves families dependent on remittances, old age pensions and gifts. UNICEF (2005b) also found that extended families in Namibia have demonstrated their willingness to care for OVCs, but that poverty was weakening the capacity of households and communities to provide adequate levels of care to OVCs. Frayne (2005) found a reciprocal relationship between urban and rural households in which transfers and remittances move both ways. He argues that mainly cash and in-kind transfers from urban areas support rural residents in times of drought and other adversities, while food transfers from rural areas assist urban households with food security. This seems to occur despite the fact that the WFP reports widespread food insecurity in some parts of northern Namibia.

Thomas (2005) argues that in the Caprivi intra-household transfers occur horizontally, i.e. from one poor household to another, and are often calculated on the basis of reciprocity. Very poor households or HIV affected household may therefore fall outside the reciprocal transfer and remittance relationships due to their inability to reciprocate transfers in the long run. Project Hope (2006, p. 12) found that over half (59 percent OVCs) received school fee assistance from a parent or guardian, 33 percent received school fee assistance from grandparents, and 8 percent from an uncle or aunt. In analysing the support networks of Child-Headed Households, Ruiz-Casares

(2005) found that friends, uncles and aunts and neighbours form the bulk of those who constitute the primary support network.

Both the World Food Programme Community Household Surveillance Survey (WFP/CHS) (2006) and Sport & Mosimane (2006) studies report very little evidence of cash transfers to HIV and AIDS affected and food insecure households. The WFP (2006) reports that 30 percent of non beneficiaries (those who do not receive its food aid) in the Omusati Region reported remittances as the main source of livelihood, but in the Oshana and Oshikoto Regions very few considered it as the main source of livelihood. Sporton & Mosimane further argue that remittances may work in the reverse.

Six percent of non elderly household heads received cash transfers from parents, and 9 percent reported contributions in kind from parents. This is corroborated by the Project Hope (2006) survey in which 57 percent of households reported cash or in-kind transfers to relatives, despite the fact over 90 percent of these households were classified as having income insufficiency. Fuller & Van Zyl (2006, p. 35) also report the transfer of cash and gifts from HIV and AIDS affected households to non-household members. They argue that the high rate of gift giving signals reciprocity within the extended family or community networks.

Frayne (2005) raises the important phenomenon of split households within families and shows how resource pooling across geographic boundaries and residential space may occur. Remittances and transfers are important mechanisms of family survival despite residential fluidity within the family group. Frayne argues that that there is a reciprocal flow of remittances between rural and urban households, particularly between households in Windhoek and those in the

Ohangwena, Omusati, Oshikoto and Oshana Regions. These cash transfers constitute the main form of remittance from the urban to the rural areas, while food transfers constitute the main form of remittance from the rural to urban areas. According to Frayne, 66 percent of Windhoek households sampled received food (mostly millet) from friends and relatives in the rural areas. Frayne's study also emphasises the enduring nature of familial ties, as the food transfers extend right into second generation urban dwellers and households where all members were born in Windhoek. This occurs parallel to signs that some of the traditional support networks are eroding. Sporton & Mosimane (2006) report a breakdown in the traditional, community-based *enjabi*<sup>xvii</sup> support system, in which neighbours and members of the community assist others with ploughing and weeding in return for food and traditional beer.

## **5.5 HIV/AIDS and Household Food Security**

Given the high levels of poverty in Namibia, many households face food insecurity. The arid climate, low and variable rainfall and degradable soils result in low levels of land capability and agricultural productivity. The signs of environmental degradation are discernable in increasing deforestation, biodiversity loss, soil erosion and bush encroachment. Besides these environmental factors, food security is further threatened in areas with high HIV prevalence rates and where most people rely on rain-fed agriculture. (United Nations, 2004, p. 14) This famine, however, is not always very visible, for it does not affect entire communities but specifically HIV and AIDS affected households. Often only they and those in their social networks are aware of the problem. (Fuller & Van Zyl, 2006) Abate et al. (2003) and Fuller & Van Zyl (2006) identify the multiple connections between food insecurity in HIV and AIDS in the labour intensive, communal crop production areas of northern Namibia, namely:

- Loss of labour as a result of absenteeism due to illness and death. Sixty percent of farmers interviewed reported loss in labour. Thus far Namibia has already lost 3 percent of its labour force, and this figure is set to rise to 26 percent by 2020 (Fuller & Van Zyl, 2006, p. 3).
- Loss of labour time as a result of long mourning periods after deaths
- The replacement of adult labour with child labour. This lowers productivity as children have less knowledge and experience of farming.
- Reduction in agricultural extension services as a result of illness and death amongst extension officers
- Changes in crops produced. Fuller & Van Zyl (2006) refer to this crop substitution as the “Devil’s Trade-off”. HIV and AIDS affected households switch from more labour intensive pearl millet (omahangu) to less labour intensive maize production. However maize is a heavy feeder and can lead to soil depletion if it is not rotated. It also requires more rain and fertilizer and is less nutritious than millet. All this could lead to greater food insecurity in the future.
- Decrease in the amount of land under cultivation. Abate et al. (2003) found that fifty percent of HIV and AIDS affected households reported a fifty percent decrease in land under cultivation in millet producing areas.
- Sale of productive assets to offset additional expenses related to illness or death
- Abate et al. (2003) found that 10 percent of households sold livestock to cover these expenses. Fuller & Van Zyl found a mixed pattern. Often HIV and AIDS affected households owned very few or no livestock. Some with larger herds tended to maintain or increase their herds while those with moderate herds reported livestock sales. This is an

indication that poor families are more vulnerable to AIDS and less able to mitigate its impact.

Fuller & Van Zyl (2006, p. 2) argue that the downward spiral in food production as a result of AIDS starts with the illness of an adult (particularly a male). AIDS diverts resources, particularly labour-time and money from productive activities towards the needs of the ill person. As a result of illness and death, heavy duty labour in the familial productive unit, like land clearing and livestock production, usually carried out by men, declines. This affects overall productivity and food security. The problem is exacerbated by patriarchal land distribution patterns and traditional matrilineal inheritance patterns that force women and children to move upon the death of the male spouse and in the process lose their access to productive resources.

Sporton & Mosimane (2006) found that in most households caring for orphans, cropping constituted over 97% of the livelihoods, and that all households were engaged in cultivation (millet, legumes, beans, sorghum, maize, melons, groundnuts, pumpkins and tomatoes). In addition elderly household heads often engage in a diverse range of activities and resources to ensure household food supply. These include fishing, gathering of veld foods, livestock and pension payments. Another interesting finding was that increased monetisation of goods and services meant that the elderly could not procure certain services to sustain food production. The care burden placed on the elderly also results in labour loss, which in turn affects crop production. The World Food Programme (WFP) Community and Household Surveillance Survey (CHS) found that in the Caprivi, Kavango, Ohangwena, Omusati, Oshana and Oshikoto Regions acutely vulnerable households were significantly more likely to have a chronically ill member than other households. This may indicate the loss in production that occurs as a result of caring for ill

persons. This is corroborated by Sporton et al. (2006) who found that illness resulted in loss in agricultural labour due to incapacity the time, mainly elderly persons spend on caring for children and the diversion of financial resources from productive investment towards treatment and funeral costs.

Numerous Namibian studies report the extent of the famine experienced by HIV and AIDS-affected households. Thirty percent of all children are unable to access adequate nutrition. (Global Fund Secretariat, 2002) The World Food Programme (WFP) Community Household Surveillance Survey (2006) conducted in the Kavango, Caprivi, Oshana, Ohangwena, Omusati and Oshikoto Regions found that 40 percent of households were acutely vulnerable to hunger. The report further concluded that this under-nutrition is exacerbated by HIV and AIDS because of the dependency burden it places on already poor single parents, elder siblings and grandparents. (Tjaronda, 2006c) Although the WFP provides food assistance to 90 000 OVCs in the six aforementioned regions, this assistance is subject to the availability of donor funds, and due to donor withdrawal, children were left without this food aid in January 2007 (Maletsky, 2007).

The Project HOPE (2006) study in northern Namibia found that 20 percent of households that cared for orphans were in need of food assistance and received it from friends/neighbours (63%), government (26%), children of the household heads (11%) and other relatives (5%). The assistance programmes, however, appear to be sporadic, irregular and insufficient and do not significantly improve overall nutritional status. Thirty-three percent of household heads felt that children did not have enough food. Similarly, Fuller & Van Zyl (2006) found that nine out of ten AIDS affected households in the Kavango, Oshana and Oshikoto Regions were faced with hunger



and food insecurity and had neither the income to purchase food nor the ability to produce enough staple crops to meet their basic nutritional requirements throughout the year.

## **5.6 Changes in family structures**

The 2000 Demographic Health Survey (Republic of Namibia, 2003b) and the Namibian 2001 Population and Housing Census (Republic of Namibia, 2003a) show average household size to be 5.1 persons. However Fuller & Van Zyl (2006) show significant changes in family structures as a result of HIV and AIDS in November 2004 compared to the Population Census statistics of 2001. They argue that increasingly households and families are headed by females because of higher male mortality rates. Women and younger members of the family are forced to compensate for the loss in productive labour. They also found that particularly in areas affected by matrilineal inheritance systems, household size increased as a result of household merges in response to AIDS mortality. Consequently regions like Oshana and Oshikoto had a higher number of adults per household compared to Kavango, where such merges do not occur. Taking in orphans is one coping strategy used to offset labour losses. Fuller & Van Zyl found a higher number of orphans in households than indicated in the 2001 Census statistics. Most of these orphans were paternal orphans due to higher rates of adult male mortality. Household size in all regions was higher than reported in the 2001 Census, ranging from between 6 to 10 persons. Haludilu (2005) also found that OVCs in Windhoek reside in rather large households. Average household size ranged between 6-10 persons, but household size could go up to 20. Although the study did confirm a high level of migration amongst OVCs it did not state if large household size was as a result of family blending or household merges. The Project HOPE (2006) study found great variance in household size that

ranged between 2-15 members with a number of household heads caring for between one to fifteen non-biological children.

Both the Project HOPE (2006) study and WFP CHS (2006) studies found that on average there were two orphans per household. Of all the regions surveyed, the Kavango Region had the most non-relatives residing in the household (> 1%). This means that households consist mainly (99 %-100 %) of related kin and that household and family boundaries by and large coincide. The study also confirms the demographic shifts caused by adult mortality since 56 percent of household members were children under the age of 14. Youth between the ages of 15-29 made up 30 percent. The study found that only 20 % of household members were between the ages of 29 and 65 years. This seems to confirm a demographic shift, as AIDS mortality depletes the middle layer in families.

In her study of HIV/AIDS-affected households in Caprivi, Thomas (2005) found that most households consisted of several generations of the same family. She also found that households were dynamic, and that household composition was often affected by the ability to access other resources like social grants and pensions. It could therefore mean that the elderly, who can access government pensions, or orphans who can obtain grants, become desirable members of the household/family.

## **5.7 Needs of OVCs**

UNICEF (2006) identified the greatest threats facing OVCs in Namibia as:

- Lack of protection

- Physical and emotional abuse
- Extreme and relative poverty
- Malnutrition and chronic starvation
- Lack of early childhood development
- Lack of access to school
- Risk of HIV infection
- Prostitution and crime
- Premature death

At the Third National Orphan and Other Vulnerable Children's Conference held in February 2005 orphans identified their most important needs as schooling, uniforms, food, money, clothing and counselling. The conference also found that OVCs experienced anxiety over the prospect of not completing their education due to an inability to pay school fees, purchase uniforms or buy food to take to school. In addition to stigma, their participation in the caring burden impedes educational advancement. (Watson, 2005) Ruiz-Casares (2004) found more or less the same needs expressed by children in child headed households. In addition they longed for parental guidance and advice.

### **Education**

Guided by the policy of "Education for all", and in compliance with the relevant constitutional provision, the Namibian government passed the Education Act (No. 16 of 2001), which enforces free and compulsory education for children between the ages of 7 and 16. In terms of article 54 of this act, a child cannot be refused admission to state schools on the basis the non payment of fees.

(Terry et al., 2007, p. 25) Despite this legal and policy framework, there is still a struggle to pay fees by AIDS affected families. The Namibia Red Cross Society (2006) study found that parents/guardians are unable to pay the school fees even when they are as low as N\$ 50.00 per annum. In addition to school fees there are also other financial costs like school uniforms, food and transport (Terry et al., 2007, p. 25).

There are many factors that can impede access to education, which include: failure to enrol, school dropout as a result of poverty, hunger, stigma, emotional and psychological stress, domestic responsibilities, child labour and abuse. (Abt. Associates, 2002) Despite all these impediments, many OVCs are staying in school. Project HOPE (2006, p. 14) found that 96 percent of orphans surveyed were still attending school, and those who dropped out were either repeaters or those who could not afford to continue their schooling. They further found that 61 percent of the OVCs received assistance with school fees, and 52 percent had notebooks, and 68 percent had writing instruments. High school retention rates amongst OVCs are also corroborated by Hadulilu ( 2005) who found that 98 percent of OVCs between the ages of 15-19 were still attending school, but that they fell behind, which made them older than other children in their grades. The age differences often resulted in ridicule by classmates, something teachers often fail to address.

Educational planners may be faced with other challenges, as the Ministry of Education predicts that 550 teachers/educators will be lost to the educational system annually as a result of AIDS deaths. The situation will be compounded by high levels of teacher absenteeism as a result of illness, which in turn will lead to inefficiencies and higher learner dropout rates. (Philander, 2006) HIV and AIDS also altered the teacher's role from merely engaging with the three Rs (reading, writing and arithmetic) to that of alternative care givers, counsellors and social workers.

(Mbangula, 2007). A UNICEF (2006 b) study shows a positive connectedness between teachers and learners and that the teachers provide a critical channel of communication with children. UNICEF (2005) predicts high teacher attrition rates will continue since it is estimated that one in seven teachers are HIV positive, and that the death rate amongst teachers will climb, despite the use of antiretroviral drugs.

## **5.8 Orphan Care Arrangements**

A clear indication that Namibia has reached the orphan phase of the AIDS epidemic is the phenomenal increase in the number of government grant and social assistance applications. In 2004 there were 7000 children who received government child support grants. By March 2006 this number jumped to 45 340. (Gaomas, 2006) Namibia’s geographic orphan distribution mirrors the epidemiological pattern of HIV/AIDS prevalence. Regions with the highest HIV prevalence also have the highest number of orphans. The regions with the highest orphan populations are the Ohangwena, Oshikoto, Oshana, Omusati, Caprivi and Kavango Regions. These regions account for over 50% of the Namibian population, generate fifty percent of all orphans and take on sixty percent of the orphan care (Watson, 2005).

Although NGOs have reported that children find the terms “orphan” and “vulnerable children” (OVC) discriminatory, the terms emerged in the context of AIDS related morbidity and mortality to identify those children, whose safety, well-being and development is threatened due to the death of parents, and therefore they face negative outcomes compared to the average child in society. (Subbaroa & Coury, 2004, p. 2) Due to high levels of poverty and other social problems there are a number of children at risk of negative outcomes even if they are not directly affected by

HIV or AIDS. The Namibian government's definition of OVCs includes all children under the age of 18 who have lost one or both parents, children who are dependent on pensioners, disabled persons, unemployed persons, people who are in prison or those who earn less than N\$ 500.00 per month. Ngavirue (2007 c) Terry (2007, p. 37) gives a long list of children who can be categorised as Children in Difficult Circumstances (CDCs). However HIV and AIDS often interact with these categories, and therefore one finds a great degree of confluence between them.

**Table 13: Children in difficult circumstances (CDCS) in Namibia**

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Working children</li> <li>• Child sex workers</li> <li>• Children of farm workers</li> <li>• Children in remote, poorly-serviced, rural areas</li> <li>• Children from minority ethnic groups that are considered to be marginalised</li> <li>• Street children</li> <li>• Children in squatter camps and resettlement camps</li> <li>• Children with disabilities</li> <li>• Children defined as over aged by educational policies (too old to be in lower grades)</li> <li>• Orphans</li> <li>• Refugee children</li> <li>• Teenage mothers with inadequate support</li> <li>• Children experiencing abusive or violent home life</li> <li>• Children infected and affected by HIV and AIDS</li> <li>• Children who are heads of households</li> <li>• Children in trouble with the law</li> </ul> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

*(Source: Terry, 2007, 37)*

Historically most Namibian communities dealt with orphanhood in accordance with custom. Lineage, descent and the payment of bridewealth/lobola were important factors in determining how orphan care is managed within the extended family. Le Beau, Ipinge and Conteh (2004) and Gordon (2005) identified at least four systems through which lineage and descent are traced in different Namibian communities:

- Patrilineal descent practiced by Nama, Damara (and presumably European, Coloured and Baster) Communities
- Matrilineal descent practiced by Owambo and Kavango Communities
- Bifurcated or dual descent practised by Herero Communities
- Cognatic descent i.e. matrilineal descent with a patrilineal influence practiced by people in the Caprivi Region

In many of the matrilineal communities children are taken in by the maternal kin. In other words, the deceased mother's family, mainly maternal grandmothers, take in orphans. It is argued that in these communities the patrilineage gets the property and the matrilineage the children. (Le Beau, Iiping and Conteh 2004, p. 35) While this may be so, the inheritance of property may also occur matrilineally. i.e. the male relatives on the father's mother's side, i.e. the mother's brother, father's brothers and father's sister's sons.

In some of these communities the avuncular rule applies even when parents are alive. Due to the payment of lobola the father can make certain decisions over the child, for example control of the child's labour, because lobola is seen as a purchase of the woman's labour, sexuality and fertility, but because of the avuncular rule, the maternal uncle (mother's brother) is responsible for the child's financial support and reprimands the child as part of the socialisation function. Under these conditions the maternal uncle can take in the child in times of distress or upon orphaning. In certain patrilineal communities the payment of lobola makes the father's kin responsible for the child's upbringing, and they take in children upon the dissolution of a marriage or upon orphaning.

UNICEF (2005 b) reports that 25 percent of Namibian households care for at least one OVC. The 2001 Population Census sets the figure at 24 percent and the 2003/4 Namibia Household and Income Survey (2006a, p. 21) set it at 23 percent. More households in rural areas (19%) have orphans than those in urban areas (8%). (Republic of Namibia, 2003a) In Namibia more female-headed households (32 %) take care of orphans than male-headed households (17%), while average per capita income in female-headed households is much lower (N\$ 6 320 p/a) compared to male-headed households (N\$ 10 570 p/a). (Republic of Namibia, 2003b) The data also show that households that have taken in orphans are likely to be poorer than households without orphans since the former spend a relatively high percentage of income (32%) on food, compared to the 18 percent of non orphan households (Republic of Namibia,2003a).

Despite the fact that the Caprivi Region has consistently had the highest HIV prevalence rates, it also has a lower percentage of households that have taken in orphans compared to some regions like Ohangwena, Omusati, Oshana and Oshikoto. While the reasons for this are not clear, it may well be that the latter regions are more affected by labour migration and have a history of fostering inside the extended family.

Migration is one of the coping strategies used to deal with the impact of AIDS in southern Africa, and in most cases OVCs migrate from urban areas to rural areas. (Ansell & Van Blerk, 2004) The high percentage of orphans in rural areas could therefore be the result of stress migration caused by adult AIDS mortality. As mentioned in Chapter 2, it could also be part of a legacy of pre-existing labour migration patterns where adults migrate to urban areas and leave behind the aged, women and children. Low marital figures increase the possibility of adoption when grandparents, aunts and uncles raise children born out of wedlock to pave the way for



biological parents to enter into new relationships unencumbered by the presence of children from other relationships.

**Table 14: Households that care for orphans by region**

<b>Region</b>	<b>Number of households with OVCs</b>	<b>Percentage</b>
Caprivi	18 607	15.0
Erongo	27 713	4.8
Hardap	16 365	8.9
Karas	15 570	7.8
Kavango	32 354	18.1
Khomas	64 918	6.4
Kunene	13 365	8.6
Ohangwena	37 854	26.7
Omaheke	13 347	9.4
Omusati	39 248	22.3
Oshana	31 759	20.5
Oshikoto	31 871	23.8
Otjozondjupa	28 707	6.6

*(Source: 2003/4 Namibia Household Income and Expenditure Survey: Republic of Namibia, 2006a)*

The 2001 Population Census indicates that 56 percent of the Namibians over the age of fifteen have never married, and that only 19 percent are married with a certificate. A further 7 percent are in consensual unions without formal status. Despite the fact that births are under reported, as some children are not registered, the 2001 Population Census concluded that motherhood starts fairly early and is significant in the late teens. (Republic of Namibia, 2003a) This means that a number of children born out of wedlock or to young mothers become the responsibility of grandparents or others in the extended family when mothers migrate in search of work or to continue their education. With AIDS mortality OVC care arrangements often follow a cyclical pattern of multiple migrations. First the father predeceases the mother, who in the context of patrilocality, may lose her right to remain on the land or may be ill treated by in-laws and therefore move to her parents to be cared for when she falls ill. After the death of the mother the

children often remain with the maternal grandparents or are taken in by maternal uncles or aunts. (Ansell & Van Blerk, 2004)

Whether the surviving parent takes over the caring burden depends on whether the child is a paternal or maternal orphan and therefore whether the surviving parent is male or female. In most cases females are more likely to take care of orphans. In the rural areas males who rely on subsistence agriculture may take in children if they need additional labour. In general, surviving male parents prefer to transfer the caring burden to grandparents or aunts. This is linked to the sexual division of labour in society, but is often precipitated by labour migration or remarriage. (Subbarao & Coury, 2004, p. 28) Where sororate marriage is not practised, new spouses are at times reluctant to accept non-biological children. The children are then transferred to other households within the extended family. (Ansell and Van Blerk, 2004)

A John Hopkins University (2006) study in Namibia found that over 70 percent of respondents interviewed felt that the extended family should take care of orphans, and the majority (75 percent) also declared that their group would be willing to take in an orphan. Ruiz-Casares (2007, p. 151) argues that the extended family is the most likely to absorb orphans, and where there is little contact with the extended family structure, children are more likely to be abandoned. This decline in kinship ties often comes about as a result of labour migration. Le Beau and Mufune (2003) provide evidence that the extended family, often the maternal grandparents, absorbs most orphans.

Despite high levels of fostering inside the extended family, adoption and fostering outside the extended family network and institutional care arrangements are regarded as least acceptable

but occur despite negative cultural attitudes towards such practices. Ruiz-Casares (2004) reports that in her study on Child-Headed Households, only 15 percent of community leaders interviewed regarded fostering by non-relatives as a viable option. Extended family care arrangements were the most favoured caring option. One of the key concerns with caring arrangements is that siblings should be kept together, and where this is not possible, relatives should ensure that they maintain regular contact.

UNICEF statistics confirm that in all countries in the southern African region the extended family forms a resilient social system that assumes responsibility for 90 percent of orphans. A UNICEF (2002, pp. 37-39) study carried out in Namibia corroborates this finding. These statistics suggest that up until 2002 the extended family structures were able to absorb most of the children orphaned by AIDS. The data also confirm that often it is the maternal kin who take responsibility for orphans. Project HOPE (2006) found that in most cases parents have made arrangements for the care of their children before the onset of sickness or death.

Fostering and caring for the children within the kinship group has been a longstanding practice even before the AIDS epidemic. In general 35 percent of Namibian households foster children, and only 26 percent of children actually live with their biological parents. Of these, 36 percent of children live with one parent, 33 percent live with their biological mothers but not their fathers, and 4 percent live with their biological fathers and not their mothers. (Republic of Namibia, 2003b) Some of these residential patterns are influenced by poverty (children are often sent to wealthier kin), lack of educational facilities in areas of origin, childbirth out of wedlock and paternal delinquency. (United Nations, 2004, p. 40)

Adoption or fostering within the extended family, however, takes on another dimension with AIDS mortality, as the element of voluntarism is eroded. Extended family members feel obliged to take OVCs because custom and tradition places those expectations on the kinship group. This type of coercive adoption and fostering could result in difficult relationships, discriminatory treatment and abuse. (Ansell & Van Blerk, p. 2004)

**Table 15: OVC Caring arrangements**

<b>Region</b>	<b>mother's kin</b>	<b>father's kin</b>	<b>non kin</b>	<b>Child headed households</b>	<b>adult siblings</b>
Kunene	5	3	1	-	1
Omusati	9	9	-	-	-
Caprivi	5	5	-	-	3
Erongo	-	6	-	-	4
Hardap	6	2	-	-	-
Karas	6	2	-	-	-
Kavango	16	3	-	-	1
Khomas	11	6	-	-	2
Ohangwena	11	3	-	-	-
Omaheke	11	5	-	-	3
Oshana	10	4	1	1	-
Oshikoto	12	1	-	-	-
Otjzondupa	6	2	1	-	1

(Source: UNICEF, 2002)

Household and familial fluidity is often associated with multiple migrations. Le Beau and Mufune (2003, p. 351) report that families may be affected by multiple AIDS related deaths, since HIV and AIDS often occur in family clusters and children move from one caregiver to the next as different members of the family succumb to the disease. This successive orphaning can also occur when elderly grandparents die or become infected with HIV as well.

Adaptation and integration in new families may be difficult, and children may feel socially dislocated or lack the cohesive space as members of a stable family. Ansell & Van Blerk (2004) and Haludilu (2005) found that the majority of orphans (65 %) have moved residence since the death of a parent, and that they are struggling to cope with both the loss of a parent and a new environment. The Project HOPE (2006) study in northern Namibia however found fairly stable caring arrangements and infrequent migration of orphans. The majority (87%) have lived in that community for over four years and did not expect to move in the near future.

### **Elderly Headed Households (EHH)**

Both the Project HOPE (2006) and the World Food Programme Community Household and Surveillance Survey (WFPCHS, 2006) found that in Namibia the caring burden is first placed on elderly grandparents followed by surviving parents and other relatives. Both studies also confirm that households that take in orphans are also most likely to be caring for chronically sick adults. The Project HOPE study found that over 54 percent of the primary caregivers of AIDS orphans were over the age of 60 years. The WFPCHS study found 54 percent of single orphans and 64 percent of double orphans lived with their grandparents.

Sporton and Mosimane (2006) found that in the Omusati Region 58 percent of households were headed by elderly people (> 60 yrs with the average age of household heads being 75 yrs) of which 62% were female. This could be due to high levels of labour migration as well as lower levels of male life expectancy. On average the elderly-headed households (EHH) have seven members, of which grandchildren form the majority. In 84 percent of the cases elderly female household heads take care of grandchildren whose parents are working elsewhere. In addition to AIDS and labour migration there is also a cultural dimension to fostering as mentioned in Chapter

two. Adults in a kinship group often assume collective responsibility for the young, regardless of whether they are their biological children or not. Since age is still an important social marker in certain Namibian groups, decisions about children's care and welfare are often made by the elderly, even when biological parents are around.

The Sporton & Mosimane (2006) study also confirms that elderly women are the primary caregivers of orphans and of people who contracted HIV, and who have become sick and returned to their rural kin for care. Nearly half the elderly household heads were responsible for caring for someone who was sick. This means an increased dependency burden on the elderly who are responsible for food, medical treatment and nutritional supplements for the sick. They face severe resource constraints, and therefore children cared for by grandparents are more likely to live in poverty and deprivation. Despite this fact, Haludilu (2005) found that in most cases children preferred to live with grandparents, even in situations of material deprivation and poverty, because they felt loved and respected, and the memory of their deceased parents was honoured.

In addition to the fact that grandparents often do not have the resources to adequately provide for children's material needs, they at times also lack the energy to provide adequate parental supervision or to deal with the psychological problems associated with orphaning. It is still unclear what the long term impact of inadequate parental supervision and emotional support will have on the children themselves and Namibian society at large.

### **Child Headed Households (CHH)**

Children of large families are often separated at funerals and divided amongst the extended family without prior consultation. The children are at times placed with family members they do

not get along with. Under these circumstances siblings may prefer to remain in the parental home or live on the streets (Ansell & Van Blerk, 2004). Child-Headed Households also emerge in situations where extended family structures are overstretched, where relatives are unable to take in the children due to poverty, where siblings do not want to be split up, or where children do not want to lose access to parents' property by vacating the parental home. (Ruiz-Casares, 2007) Child-Headed Households are then often headed by children between the ages of 15-19 years who take care of younger siblings (UNICEF, 2002).

Some indications are that child-headed households are not so widespread in Namibia. In the Project Hope (2006) sample only 1% of Child-headed households were headed by a person below 19 years old. The WFP/CHS (2006) study used a much bigger sample (2575 children between 0-18 years) and found that Child-Headed Households are not very common. They only found two households headed by individuals of 18 years. None of the households surveyed had household heads who were younger than 18. Haludilu (2005) found only 2% of Child-headed households in her needs assessment of OVCs between the ages of 15-19 years in Windhoek. In one case they were double orphans who preferred to remain together.

Ruiz-Casares (2004), in her study on Child-headed household in northern Namibia, used an expanded operational definition of Child-headed households to include those households headed by persons younger than 21 years of age who are not the biological parents of younger children in the household. It also included children who were living in the same homestead or in close proximity to other relatives. Out of the 34 households interviewed, the average age of the household head was 17 years and average household size was three. The majority were double orphans, but some had parents who were either working elsewhere or had left the children close to

schools so that they could continue their education. Those who were orphaned reported that relatives did not want them, did not offer to take them, ill-treated them (one household), or that siblings did not want to split up. Ngavirue (2007 a) makes the distinction between child and youth-headed households and applies the Ministry of Gender Equality and Child Welfare's criteria to include households headed by young people below 25. He also found a household headed by a child as young as fourteen years old.

Illness and death of adults often lead to changing roles and responsibility in the family. Children in CHHs often have to take on adult responsibilities. Ruiz-Casares (2007) argues that in addition to the stress experienced with the illness and death of parents and the collapse of the family unit, orphaned children, particularly girls, are often disadvantaged as a result of the new responsibilities like caring for the sick, younger children and the need to seek income generating opportunities.

### **Institutional Care**

Haihambo et al. (2004) found that children in residential care (homes or orphanages) are most needy, with inadequate food and bedding. They often live under unhygienic conditions with little evidence of two-way communication between caregivers and children. These children are more prone to stigma, discrimination and social exclusion as they are isolated in compounds and do not interact with non OVCs. They also found a lack of training amongst caregivers. This could lead to the misuse of medicines in cases where children are HIV positive, misunderstanding of vaccination and treatment procedures, lack of birth registration and inadequate adult supervision, as smaller children are often left in the care of older children. (UNICEF, 2006a)



Institutional care for orphans is regulated by the Children's Act. The Act (33 of 1960) requires that such institutions be registered with the Ministry of Gender Equality and Child Welfare MoGECW, but formerly with the MoHSS. The MoGECW provides training and subsidies (N\$10 p/d per child) to such institutions. Since the emergence of the orphan crisis, a number of informal care arrangements have emerged within the extended family and communities. Terry et al. (2007, p. 39) argue that at times the children's homes provide inadequate care and drive children away to eventually become street children.

## **5.9 Other challenges faced by OVCs**

### **5.9.1 Child labour**

The literature distinguishes between three forms of child labour found in Namibia. **Child Work** is work done in the family or in the community that is beneficial to the development of the child as well as their family and community. **Child Labour** exploits children and is harmful to their development or interferes with their education. **The Worst Forms of Child Labour (WFCL)** include the commercial sexual exploitation of children and the use of children to commit crimes. Although Namibia ratified the following conventions and protocols, there are strong indications that child labour is a common feature in Namibian society, particularly in rural agriculture. (Terry et al., 2007, p. 14)

The indications from international studies are that child labour increases as a result of the impact of HIV and AIDS. (Republic of Namibia, 2000) Abate et al. (2003) found that there is a substitution of adult labour with child labour in Namibian farming. Ruiz-Casares (2005) found that two out of three children interviewed in Child-Headed Households frequently worked to earn

food or money. They do agricultural work and domestic work like stamping millet, fetching firewood and water, cleaning yards, washing and cooking for money or food. The lines between child work and labour are, however, blurred, because it requires a value judgement to determine what is harmful and what is socially acceptable. Traditionally children in rural Namibia were required to contribute towards agricultural labour in accordance with their age, gender and physical abilities.

In addition to the Constitution there is the Labour Act (2008) which protects the rights of children. The Namibian government also ratified a number of international protocols to prevent child labour as cited in the table below

**Table 16: Child Labour Conventions and Protocols ratified by the Namibian Government**

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• ILO Minimum Age Convention (C138) (No. 138 of 1973), ratified by Namibia in 2000</li> <li>• Worst Forms of Child Labour Convention (C182) (No. 182 of 1999), ratified in 2000</li> <li>• African Charter on the Rights and Welfare of the Child, signed in 1999</li> <li>• UN Convention on the Rights of the Child (CRC), ratified in 1990</li> <li>• Optional Protocol on the Involvement of Children in Armed Conflict, ratified in 2002</li> <li>• Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography, ratified in 2002</li> </ul> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

*(Source: Terry et al. 2007, p. 14)*

A recent workshop organised by the ILO found that children in northern Namibia were engaged in farm and agricultural labour. The workshop also revealed that in the northern towns of Ondangwa, Eenhana, Outapi, Oshakati and Oshikango children were recruited into the sex trade. (Mbangula, 2007) Terry (2007) argues that OVCs are faced with the premature need to support

themselves economically and may therefore be pushed into vulnerable economic activities such as street trading, begging, crime, and commercial sex work. The Namibia Red Cross Society (2006) study in Ohangwena Region found female OVCs do turn to prostitution for survival. Kiremire (2007) found that male OVCs are often involved in criminal activities.

While there is evidence the OVCs are vulnerable to sexual exploitation and may engage in risky sexual behaviour as a result of economic necessity, the UNICEF (2006 b, p. 21) study found that they are less inclined towards risky sexual behaviour than non orphans, because of a greater awareness of the repercussions of risky sexual behaviour. This somewhat contradicts Kiremire's other finding that 94 percent of prostitutes are orphans, and that 86 percent engage in prostitution because of poverty. The CADRE study (Tjatindi, 2008) also expressed concern about the fact that young people generally engage in sex at a much earlier age than the generations before them, this despite high levels of HIV/AIDS education and information dissemination and at times personal involvement in community level HIV/AIDS responses.

Ruiz-Casares (2007, p. 151) found that young children who are orphaned are often overworked and underpaid and engage in transactional sex as a survival strategy. UNICEF (2006 b, p. 21) found that where HIV orphans missed school it was because they were ill or had to move to live with someone else. None however missed school because of work.

The question of child labour and children's exploitation remains under researched. A 2008 United States of America State Department report, however, cited Namibia as one of the countries where possible child-trafficking occurs. The report concedes that there is insufficient evidence to substantiate its suspicions, but nonetheless goes further to speculate that Namibian children are

trafficked within the country for domestic servitude, forced agricultural labour, cattle herding and vending. There is also the suspicion that Zambian and Angolan children are trafficked to Namibia for domestic servitude. (Maletsky, 2008 b)

### **5.9.2 Inheritance and Property Rights**

As mentioned in Chapters 2 and 3, due to certain customary inheritance patterns, widows and children often lose land and other property rights upon the death of a husband/father. Amongst Ovambo groups the wife may be given a year to return to her kin upon the death of her husband. (Lebert, 2005 p. 75) These inheritance practices result in the impoverishment of women and children upon the death of a husband, and human rights groups have called for the outlawing of these customary inheritance systems.

To combat customary inheritance laws the Namibian government promulgated the Communal Land Reform Act (2002) which makes provision for women and children to inherit land use rights held by their husbands, but this has created legal pluralism since in many instances customary inheritance laws are still applied to the disadvantage of women and children. The Act tries to correct skewed property ownership patterns in favour of women, and therefore provides the legal basis for female leasehold and the acquisition of customary land rights. The Namibian government is also currently reviewing the Succession Bill in order to guarantee land and property rights to surviving spouses and children of deceased persons. (Republic of Namibia, 2005c)

Women's and children's testimonies at the National Conference on Women's Land and Property Rights (Republic of Namibia, 2005c) revealed that the extended family (departed husband's kin) were the main perpetrators of disinheritance and property grabbing. In addition to

land, water rights and cattle, they also take pension payouts, insurance payments, houses, house fixtures, cars, diverse household and personal items like beds, linen, cooking utensils and roof sheeting. In some cases they claim the children in order to gain control over the pension and death benefits of the deceased parents.

Ruiz-Casares (2007, p. 151) found that some traditional authorities have started to waive the land transmission fee to allow women and children to remain on the land occupied by the deceased husband. Women are often not aware of their rights or are intimidated and threatened into relinquishing these rights.

### **5.9.3 Stigma and Discrimination**

The problems experienced by orphans can be divided into two categories, namely psychosocial and material. The Second National Conference on Orphans found that OVCs experience stress related to grieving, avoidance by others, teasing, social isolation, discrimination, stigma and self stigmatisation. (Republic of Namibia: 2002) This trend is corroborated by UNICEF (2006a) who found that AIDS orphans face different forms of stigmatisation. This however contradicts Ruiz-Casares' (2007, p. 157) findings that children in CHH were generally not aware of different treatment by others. At times they denied that AIDS caused their parents' deaths. This denial could be a way of avoiding stigmatisation. The study also found a culture of silence surrounding AIDS, as most children interviewed did not want to mention the word AIDS and referred to it as "the disease". This could be seen as a strategy to avoid stigmatisation.

Discrimination may come from members of the community and from within the extended family. Where extended family members feel obliged to adopt orphans, they may harbour

resentment towards the new members of the family. So far Namibian studies have not reported large-scale abuse and discrimination of orphans in adopted families, but Ansell and Van Blerk (2004) found that in Lesotho and Swaziland adoptive parents at times discriminate against non-biological children. They are given different food, beaten, and are overworked. The biological children of adoptive parents may also resent the fact that they have to share resources with their new siblings. Haludilu (2005) found that 88 percent of the OVCs felt comfortable with their caregivers. Ten percent were not satisfied and cited mistreatments and feelings of being unloved as the main reasons for their dissatisfaction. Thomas (2006) found that in the Caprivi Region stigmatisation and discrimination are linked to resentment about the caring burden that is transferred to surviving family members, because the infected did not act on advice to avoid HIV infection. She also found a breakdown in familial relations, and that accusations of witchcraft were used as a basis for refusing assistance to AIDS-affected households.

### **5.10 Government's responses to orphan care**

In November 2008 Namibia was ranked as the second most child friendly country out of 52 in Africa. This is based on a child friendly index that assesses a government's performance in the protection of children through laws, policies and budget allocations. (Tjaronda, 2008) The Namibian government's overall response to HIV and AIDS consists of five key programme goals (Republic of Namibia, 2004b)

- Creation of an enabling environment that will enable infected and affected people to enjoy their rights in a culture of acceptance, openness and compassion
- Prevention and reduction of new HIV infections
- Access to treatment, care and support services for infected and affected persons

- Capacity creation for impact mitigation in response to the socio-economic impact of HIV/AIDS
- Integrated and co-ordinated programme management at all levels

The First and Second Medium Term Plans on HIV/AIDS paid very little attention to OVCs. The Third Medium Term Plan (MTP III) (2004-2009) makes provision for impact mitigation with particular reference to comprehensive services to OVCs. These include the adoption of an OVC policy, the development of an OVC Trust Fund, simplification of access to grants, dissemination of information on support services available, establishment of counselling and child health care services, expansion of early childhood education centres, training of peer educators, training of justice officials, social workers and educators. The Plan also makes provision for addressing poverty, food insecurity, the nutritional and housing needs of families affected by HIV and AIDS.

Namibia has adopted a Human Rights approach (HRA) towards the rights and entitlements of those infected and affected by HIV/AIDS. The OVC policy principles reflect this: They include:

- The best interest of the child as the overriding consideration in developing a national response to the OVC phenomenon
- Sustained political leadership commitment
- Multi-sectoral approach and partnerships
- Promotion and protection of human rights
- The right to survival, life and development

- Orphan-centred approach which includes their participation in developing a response
- Child-centred and family and community focused approaches

Fundamental protections are contained in the Namibian Constitution. Article 15 of the Constitution identifies a child as a person under the age of sixteen and compels the government to enact legislation that protects them from economic exploitation and protects their physical, mental, spiritual, moral and social development. Article 20 makes provision for free and universal education up to the age of sixteen. Article 6 protects their right to life. Article 8 ensures respect for human dignity. Article 10 protects them from discrimination.

The Maintenance Act (No. 9 of 2003) assigns a legal duty to parents to maintain their children. (Terry et al. 2007, p. 23) On the 6<sup>th</sup> of November, 2008 the Child Status Act of 2006 came into effect. The objective of this Act is to promote and protect the best interest of the child and to ensure that no child suffers disadvantage or discrimination because of the marital status of the parents. (Republic of Namibia, 2006) This Act will be pitted against traditional customs as it grants the same rights to children born inside and outside of legal marriage. This means that customary inheritance practices can be challenged in a court.

The Namibian government is signatory to a number of international protocols, such as the Convention of on the Rights of the Child and the African Charter on the Rights and Welfare of the Child and the Tunis Declaration on AIDS and the Child in Africa and the Abuja Declaration (Centre of the Study of AIDS, 2004), which assert similar rights and entitlements to children as contained in the Namibian Constitution.



In line with the policy recommendations of dominant international institutions like the World Bank, Namibia has adopted a family-community oriented approach to HIV/AIDS impact mitigation, particularly in the area of orphan policy. The World Bank argues that household and community level interventions are more cost effective than institutional care options. (Subbarao and Coury, 2004) Namibia's policy approach is to keep OVCs inside the family or community network rather than to institutionalise them.

Key interventions outlined in the policy include strengthening the capacity of families, social networks and communities to protect and care for OVCs, creating an enabling environment for affected children and families and the provision of essential services to children as outlined in the table below.

**Table 17: OVC policy interventions**

Livelihoods and food security	Education	Upholding rights
<ul style="list-style-type: none"> <li>-Assistance to increase food production</li> <li>-Support the productive base of communities</li> <li>-Access to employment</li> <li>-Access to markets</li> <li>-Income generation</li> <li>-Micro- enterprise and micro finance</li> <li>-Social grants</li> <li>-Emergency food supplies</li> </ul>	<ul style="list-style-type: none"> <li>-Fee exemptions</li> <li>-Exemptions from uniforms</li> <li>-Counselling</li> <li>-School feeding schemes</li> <li>-Referral system</li> <li>-Special needs identification</li> </ul>	<ul style="list-style-type: none"> <li>-Address stigma and discrimination</li> <li>-Registration of births and death at</li> <li>-Provision of places and safety</li> <li>-Access to legal services</li> <li>-Awareness raising about wills</li> </ul>

*(Source: National Policy on HIV/AIDS Policy, 2007)*

## **5.11 Institutional Framework to assist OVCs and AIDS affected Families**

### **Government**

The lead government ministry responsible for overall co-ordination and management of HIV/AIDS in Namibia is the Ministry of Health and Social Services. Within this ministry there is a special National AIDS Committee (NAC) that is second only to Cabinet with regard to HIV and AIDS decision making. The NAC brings together the ministers and key decision makers in various government agencies and ministries. Responsibility for AIDS policy implementation rests with the National Multi-sector AIDS Co-ordination Committee (NAMCOC) that consists of the Permanent Secretaries of different government ministries as well as representatives of regional and local authorities, Non-Governmental Organisations (NGOs), Women's organisations, Chamber of Commerce, Trade Unions and Faith Based Organisations (FBOS) and UN agencies. Republic of Namibia, 2004b)

With regard to OVCs, the Ministry of Gender Equality and Child Welfare (MGECW) is the lead governmental agency specifically charged with OVC related policy and programmes. MGECW is for example responsible for the identification of OVCs and affected households, and the implementation of certain services to OVCs and affected households, including the legal care and protection of children. (Terry et al: 2007, p. 38) Due to the nature of their work, a number of government ministries are confronted with the orphan crises. They are Ministry of Education, Ministry of Youth and Sport, and Ministry of Local Government and Housing. Each of these ministries has certain responsibilities outlined in the Third Medium Term Plan 2004-2009 (MTP III). Due to a Cabinet decision the OVC Steering Committee was enlarged in 2002 to become a Multi-Sector Permanent Task Force on OVCs. (UNICEF, 2005b) The Permanent Task Force

(PTF) on OVCs is tasked with facilitating the National Response to OVCs and translating policies and programmes into concrete actions. (Terry et al., 2007, p. 38)

In 2003 the Namibian government initiated an Orphan Fund with an initial allocation of N\$ 10 million by the Office of the President. Despite this, it is estimated that the country needs about N\$ 34 million annually to provide for the needs of registered orphans. These registered orphans account for only ten percent of all orphans, and it is estimated that if all orphans are taken into account, the fund requires N\$ 340 million per annum. (UNICEF, 2006a)

Since 2005 the Ministry of Gender Equality and Child Welfare has set up OVC forums in seven regions with the assistance of UNICEF and USAID. The forums were set up to co-ordinate the OVC response at regional and constituency level. They should also ensure that the rights of OVCs are upheld with regard to health, education, care and support. They are also supposed to monitor regional work plans. (Tjaronda, 2008b)

## **5.12 Actual Services to Orphans**

A number of programmes that target OVCs have emerged over the last five years. Programmes on offer are run by government agencies, NGOs and CBOs, and faith-based organisations as well as private sector initiatives. There is, however, little by way of monitoring and evaluation to ascertain the coverage of these services and the extent to which they can strengthen families affected by AIDS morbidity and mortality. Some of the programmes emerged on an informal basis in response to immediate needs within communities and are not registered with authorities. The Ministry of Health and Social Services has signalled its intention to register

informal orphanages and caring facilities. Often impact mitigation is regulated by custom rather than the law, and it still remains a challenge to harmonise the legal plurality that for example regulates inheritance in the case of AIDS deaths or formal requirements to access benefits.

In addition to a host of government agencies responsible for OVC services, NANASO (2005) recorded a total number of 243 HIV/AIDS civil society organisations that jointly employed over one thousand staff members and used over 15 000 volunteers in its service delivery. The majority of these organisations are involved in HIV/AIDS prevention activities through education, training, behavioural changes, counselling, testing, condom distribution and home-based care programmes. Since the NANASO study does not specifically disaggregate data for OVC services, it is difficult to ascertain the coverage and support for OVCs and families that host them.

Sporton et al. (2006) show that only 4,5% of households received government child assistance grants due to a lack of information, low levels of literacy, lack of transport to government offices, time constraints due to other agricultural activities and difficulty in registering orphans for these grants. The Project Hope (2006) study found a higher coverage of OVC grants, with 17% of households that care for OVCs accessing them. The Ministry of Gender Equality and Child Welfare concedes that access is a problem, and that orphaned children face a host of problems accessing the documentation such as birth and death certificates needed to register. In addition they lack the funds to travel to regional government offices where they can register or lodge applications to access funds. (Tjaronda, 2007c) In 2007 the Namibian government announced its overall, OVC five year plan which includes increased programme expenditure to N\$2.09 billion to support 128 000 orphans. (Wiedlich, 2007c) By November 2008 the Ministry of

Gender Equality and Child Welfare reported that 97 859 OVCs were receiving grants. This is a huge increase from the 9 000 that were receiving grants in 2004. (Tjaronda, 2008 b)

Ruiz-Casares (2004) reports a number of networks available to orphaned children in Child-Headed Households. These networks are mainly comprised of friends, neighbours or members of the kinship group. While adults were not permanently present in these households, most affected children had regular contact with adults in their support networks, often on a daily basis, and 70 percent of adults in the support network lived in close proximity to the children. Persons in the support network provided food, advice, clothes, school fees, uniforms and materials, toiletries or money. Despite this support, children still have unfulfilled needs that include food, clothes, educational assistance (fees/uniforms/materials), guidance, toiletries, blankets, and agricultural input like tractors and medical services. A study by the Namibian Red Cross Society (2006) in the Ohangwena Region of northern Namibia, found that those concerned with the needs of OVCs repeatedly pointed out food, clothes, school fees and blankets as some of the most immediate needs.

In an assessment of services available in Windhoek, Haihambo et al. (2004) found the following services and programmes available to OVCs:

- **Survival Programmes:** Distribution of goods and services to families and OVCs, safe houses, home-based visitations, soup kitchens, emergency and temporary accommodation , fostering

- **Health Programmes:** Purchase vouchers for ARVs and other medical treatment, health services, nutrition programmes, exercise and massages, voluntary testing and counselling, information dissemination
- **Psycho-social support:** Home-based visits, counselling, support groups, promotion of adoption of OVCs
- **Education and Training Programmes:** Training volunteers and home-based visitors, day-care programmes for children, children's camps, after school tutoring, school fee vouchers, provision of school uniforms, bursaries, school lunch and day care programmes for children in residential care
- **Freedom of expression, choice and movement:** Income generating programmes, awareness raising and advocacy

The Project Hope (2006) study also found a range of support services to AIDS affected households, orphans and sick persons. Children's education received the most support, and of those attending school, over half (61%) received assistance with school fees and supplies, mainly from a parent, guardian, aunt, uncle, sibling or grandparent. Watson (2005) found a number of OVC support programmes were funded and implemented by a number of organisations as reflected in the table below:

**Table 18: AID /Support to OVCs**

Service	Description	Provider	Number of OVCs p/y
Food	School feeding, Meals, food parcels	MBEC, NGOs, CBOs, FBOs, WFP	104 000 8 000 110 000
Education	Fees Exemption School Uniforms School Funds Training Register OVC in ECD	MBESC NGOs/FBOs NGOs/FBOs NGOs/FBOs MWACW (now MGEWC)	Unknown 11 157 330 870 1220
Health	Referral ARV Therapy Treatment Compliance Nutrition Monitoring	NGOs/FBOs MoHSS NGOs/FBOs MoHSS	Unknown Unknown Unknown Unknown
Psychosocial Support	After-School programmes Kids Clubs/ Camps Counselling	MWACW/NGOs/FBOs Schools and NGOs MBASC/NGOs	2000 Unknown
Financial	Nurseries Social Assistance Grants Emergency Assistance Supplies		
Protection	Programmes on Abuse Place of Safety/Homes	NGO W/NGOs/FBOs	
Trained	Counsellors, Volunteers, Teachers, Caregivers	NGOs, FBOs, MoHSS, , MWACW	Unknown

(Source: Watson, 2005)

## **Chapter 6: Presentation of empirical findings**

### **6.1 Introduction**

The data presented in this chapter emanate from a field study on the effect of AIDS-related adult mortality on family structures. Field work was done in an urban and a rural area. The empirical data in the urban area was mainly collected in the informal settlements of Havana and Okahandja Park as well a few other sites in Katutura, Windhoek, Namibia's capital. Empirical data collection in the rural area occurred in the Ohangwena Region primarily in villages around Eenhana, Engela and Okongo. For full methodological discussion refer to Chapter 1.

### **6.2 ARV Treatment**

As discussed in Chapter 4, treatment is crucial to the survival of PLWA. Successful ARV treatment can prevent premature death in caregivers, and this affects the ability of AIDS affected families to reproduce themselves as economic and residential units. It was in this context that the question of treatment access was probed.

A number of NRCS volunteers and social workers at hospitals confirm a definite decrease in morbidity and mortality rates since the introduction of antiretroviral treatment (ARV). Some of the NRCs volunteers interviewed were initially trained as home-based care workers (HBC) and provided palliative care to AIDS patients. This part of their work has decreased. They all confirmed that the introduction of ARVs has brought about new hope to PLWA. Some of the community based volunteers are themselves HIV positive and related stories of the stark improvements in their own physical condition. They are enthusiastic about spreading messages of hope and positive living to others.



This positive development should reduce the strain of the care burden on families. However there is still a lot of stigma that stops HIV positive persons from coming out and accessing treatment. Key informants claim that in villages there are still families who hide their HIV positive members when they fall sick because of the fear of stigmatisation. In addition people receive treatment at specialised ARV clinics run by the Centre for Disease Control (CDC) at district hospitals all over the country. According to some community based volunteers, some PLWA fear that their association with CDC clinics would lead to their stigmatisation, and therefore they do not visit these clinics. All commended the government's ARV roll-out, but pointed to a number of factors that impede treatment access and adherence:

**a) Treatment Costs**

Despite the fact that ARV treatment is highly subsidised by donor agencies, patients still find it difficult to pay the small user fee they have to pay when they fetch their drugs at health care facilities. Key informants stated that the fee carried by the patient is between N\$6.00 to N\$10.00 per month, but even this may place treatment beyond the reach of some, particularly if a few members of the same family are on treatment. i.e. the father, mother and children.

In addition to visits to government run health facilities, people still consult traditional healers at high costs. Some deem traditional healing more holistic as it combines treatment with counselling. It also combines spiritual and physical healing. Health workers and community leaders explained that people at times prefer to visit traditional healers above the impersonal and abusive treatment they have to endure at state run health care health facilities. Visits to traditional healers could cost anything between N\$ 700.00 and N\$1000.00. Families often combine resources to afford visits to traditional healers.

**b) Food security: hunger and starvation**

Lack of food and hunger was one of the most common problems cited by caregivers, OVCs and key informants. Household food insecurity is acute in both urban and rural areas. Although no specific questions were asked about hunger or food security, there is a pre-occupation with it. It constantly came up in response to other questions. As other research has shown, hunger and nutritional deficiency pose serious threats to treatment adherence and the life-saving properties of ARVs. After completing this fieldwork it was reported that one of the NRCS volunteers died despite being on ARVs. Colleagues attributed her death to inadequate nutrition.

What was confirmed was that intra-household transfers are multi-directional. While rural households may receive cash transfers from urban wage/sector employees, they often transfer food to urban households. Despite the fact that food insecurity was a major concern, 63 percent of all rural households make food transfers to other households.

Food insecurity also plays a big part in child migration. As reported in Chapter 4, evidence from other countries shows that stress migration is often in response to AIDS related adult mortality. Household heads interviewed in urban areas reported food insecurity as one reason why they have sent their children to, or left them with, relatives in the rural subsistence economy, because they are unable to care for their children particularly after the death of a male partner. Twenty nine percent of the women interviewed in the urban area had children who were residing in the rural areas. Food insecurity and poverty were the most frequently cited reasons for this migration. Another important reason why they sent or left their children in the rural areas was education. Some argued that education is cheaper in the rural areas. The children are mainly posted to grandparents, uncles, aunts or grandaunts in the rural areas where education is cheaper.

### **Lack of food as a major concern**

*“All my children, three boys and a girl are in Ovamboland with my mother. I can’t keep them here because I don’t have enough food for them.”* 30-40 year old HIV positive, unemployed female, from Wanaheda, Windhoek, Khomas Region

*“They are my grandchildren and the children of my children. I don’t know where to put them as one is on ARV and every month I need medicine and fresh food for the medicine. Their mother passed away while she was living with me.”* 41-50 year old grandmother from Havana, Katutura, Windhoek, Khomas Region

*“I have four children, three boys and a girl. They are all in Ovamboland and are being cared for by their paternal grandmother. They are there because in Windhoek I can’t afford to feed them.”* Unemployed HIV positive female between the age of 22-30 from Havana, Katutura, Khomas Region

*“I have noticed a change in my family life because I don’t have school uniform and I don’t go to school with food. Hunger is what I can say is the change in my life because I used to carry food to school when my mother was still alive.”* 13 year old double orphan from Eenhana, Ohangwena Region

*“There was no food because my mom was not working.”* 21 year old double orphan from Havana, Katutura, Khomas Region

*“I want food in my house to eat with my family.”* 7 year old paternal orphan from Okongo, Ohangwena Region

*“It was good that you came to ask us how we feel, but next the time you come first ask if we have food at home.”* 12 year old paternal orphan, Eenhana, Ohangwena Region

### **c) Transport Costs**

Some people on ARV treatment complain that the biggest expenditure associated with treatment is not the treatment itself but the transport costs to CDC clinics and hospitals. In the Ohangwena Region the CDC clinics are at the district hospitals of Eenhana, Okongo and Engela. Certain villages are more than 70 km away from the nearest district hospital. Some sick people have to walk distances of up to 10 km to reach a tarred road where they can access public transport. In some areas public transport is simply absent, and people have to rely on private cars that they hire to get to the district hospitals. For people in remote rural villages transports costs could exceed N\$100 dollars per visit to a CDC clinic.

Both in the urban area (i.e. informal settlements on the periphery of the city) and the rural area high transport costs pose a serious threat to treatment adherence. Social workers are then roped in to follow up on those who fail to turn up at CDC clinics to get them to restart treatment. At times the extended family or community members assist with transport costs. The social workers reported that they also advise on income generating projects to mitigate the problem. Often elderly caregivers of children on ARVs and PLWA simply don't have the physical capacity, and can't make the trips to the clinics.

**d) Side Effects of Treatment**

Health workers report that a few people have dropped out as a result of the side effects of treatment.

**e) Lack of knowledge**

Grandmothers who act as primary caregivers lack information and training on the treatment regimes and some do not administer the medication properly.

**f) Monitoring Treatment Adherence**

Home-based care (HBC) volunteers and treatment supporters monitor treatment adherence. In one case the HBC volunteer reported that depressed ARV patients already tried to commit suicide by overdosing on ARVS when a patient is at risk of suicide. The volunteer keeps the drugs with her and only takes the prescribed dosage to the patient on a daily basis.

## **6.3 The effects of AIDS mortality on family structures**

### **6.3.1 Effects on family form**

As reported later in this chapter, this study found high congruence between household and family boundaries within the research population. In particular over 95 percent of households consisted exclusively of related kin. Where there were households with non-kin members, related kin constituted the core of the family or domestic unit.

It may be difficult to discern the effects of AIDS mortality on family form as AIDS often intersects with poverty and migration. There are multiple points of intersection between these factors. AIDS mortality, together with migration and poverty, affect the form, size, residential patterns and resource pooling arrangement within families.

All household heads interviewed were caring for OVCs, but not all OVCs are vulnerable because of AIDS mortality. Since the NRCS and KWID do not make the distinction between AIDS related and other forms of mortality, it was difficult to separate children and households specifically affected by AIDS from other forms of vulnerability. However from questions on the cause of death of family members reported later in this chapter, it is clear that the majority of families affected by mortality cited AIDS as the cause of death. Over 90 percent of household heads interviewed reported that there were deaths in their households. As explained later in this chapter in some cases AIDS mortality may have been under reported because of the stigma associated with it.

### **Matrifocal Family**

The designation male or female-headed household does not reveal much about the family form that is within the household. Different configurations brought about by labour migration, low marital rates, polygamous unions and high adult mortality rates suggest more transient family forms that cannot simply be read off blunt designations of male or female-headed household. This calls for more nuanced interaction with the empirical data.

Although blood ties form the fundamental basis of the family group, it takes diverse and at times complex forms. In the rural area the majority of families encountered were matrifocal families headed by elderly females. In the urban area 42 percent of households were male-headed, compared to 25 percent in the rural area. In rural areas the number of matrifocal families may be higher than the statistics suggest since males who have migrated to the urban areas at times abandon their wives in the rural area, but are still regarded as the household head even when they seldom visit or send remittances. In one case the elderly female household head reported that her husband migrated to Walvis Bay over 35 years ago, and that he took another wife, but that she regarded herself as still married to him even if he never visits. He however did take in their sons, who also migrated to Walvis Bay when they became adults.

While the matrifocal family was the most frequently observed family form, the reason for this is not so clear and could be related to a number of factors, such as labour migration, premature male mortality and poverty. The prevalence of the matrifocal or FHH supports data from the 2003/4 NHIES (2006) that suggest that household size, age of household head, level of education and gender are important determinants of household poverty. An analysis of the NHIES statistics also reveals that source of income is an important determinant of poverty.

The age of household heads was also reflected in the main sources of household income. The NHIES (2008) data reveal that in Namibia, in forty nine percent of poor and 28 percent severely poor households, pension payments are the main source of income. In this study seventy three percent of rural household heads interviewed cited pension payments as a source of income, compared to only 14, 3 percent in the urban area. This suggests that the elderly female household is more prevalent in rural than in urban areas.

In some instances matrifocal families headed by the elderly female are brought about by mortality. However, judging from examples elsewhere, it could also be part of a non AIDS-related, demographic transition. The demographic transition theory of Barquero and Trejos (2003) cited in Chapter 2 argue that an increase in the incidence of poverty increases the number of female-headed households. Poor familial households can also show a tendency towards ageing, as poverty delays fissions, and young people are less able to set up independent households. This is either because of unemployment or lack of resources resulting in more elderly-headed households. AIDS related mortality complicates this feature through the decimation of the middle layer.

### **The split household**

In Namibia the high, out-of-wedlock birth rates and labour migration also contribute to the elderly-headed households, particularly in the rural areas. Interviews with younger household heads in the urban area confirm that some left children born out-of-marriage behind in rural areas. Interviews with OVCs revealed that children born outside marriage often do not know the whereabouts of their fathers. Interviews with elderly household heads confirmed that mothers or fathers leave children born out of informal or causal unions with grandparents when they move out to start new unions and bear other children with other partners. The grandparents then become the

de facto parents. The mothers or fathers may however support the children financially, visit them occasionally or host them during school holidays where they bond with their half siblings out of new unions. The result is an interesting configuration of families separated by households and geographic space, with different household heads. There is economic co-operation and consultation around major decisions that affect the children between households as reported later on in this chapter.

What is important to note is that not all children in the care of elderly grandparents are AIDS orphans. In the field study it was common to find an elderly grandmother caring for children even when both or one parent is still alive. This supports the findings of the 2000 DHS (2003) that reports the phenomenon prevalent in southern Africa where migrant workers leave children behind to be cared for by other kin (often grandparents) It also supports the proposition that this author makes in Chapter 2, i.e. that culturally and historically there was a tendency to separate the social functions of parenting from the biological function of genitor. Children therefore are often raised by the members of the kinship group rather than biological parents.

Often stepparents do not want the children in their homes, and they remain with the grandparents. Some household heads indicated that the OVCs were brought to them by their biological fathers or mothers because they remarried or took new partners and that it seemed inappropriate to keep the children with them, in the same household with the stepparent.

### **Extended matrifocal family**

The field study revealed that matrifocal families can be extended vertically or horizontally, or can evolve out of various combinations of the two. For example the extended matrifocal



family could consist of a single, elderly, female household head, with a few of her unmarried adult children, in addition to orphaned grandchildren whose parents may have died of AIDS. It may also be a single elderly female with a few grandchildren who have different mothers or fathers. Some may have died of AIDS, some may have migrated and some may have left the home to marry, leaving children born out of wedlock behind. Although these grandchildren do not share the same biological parents, they are raised as siblings by the grandmothers. Adult children who work in the wage labour sector may send remittances that help to support the grandmother and the children of their siblings. These extended family forms may therefore combine horizontal and vertical connections or be intergenerational and intra generational at the same time.

### **Consanguine family**

In Havana, Windhoek evidence of the consanguine family form was also found. The children of one dissolved, female-headed household were traced. This household formerly consisted of a consanguine family, constituted of a number of sisters and their dependent children. All six sisters were HIV positive and eventually died. After the death of one sister, the remaining sisters took care of all the children. When the last sister died, it became a child-headed household, and community members alerted a local newspaper to the plight of the children. The newspaper in turn traced the grandmother and placed the children in a school hostel.

In the rural area there was one household that consisted of orphans, their children and the child of a deceased sister. The female household head was twenty two. So this could also be seen as a youth-headed household. In this particular case the household head was unmarried with a child of her own, one child was her deceased sister's child and four were younger brothers and sisters for whom she has been caring since both parents died of AIDS.

**Polygamous family**

In the rural and urban areas there was evidence that the polygamous family still exists, as household heads reported that they were raising the children or grandchildren which their departed or still living husbands had with co-wives. In one instance in the urban area, the husband was still alive and sojourning between the rural and urban homes of his co-wives, while the urban wife was a domestic worker, who had no biological children but was raising some of the children her husband had with other wives. In the rural area the wife of a local chief was interviewed. She too was in a polygamous marriage and raising children of her husband's co-wives.

Social workers and NGO staff complained that maternal orphans are at times ill treated by their father's co-wives and therefore moved to their maternal kin. This story was often echoed by the OVCs who were interviewed.

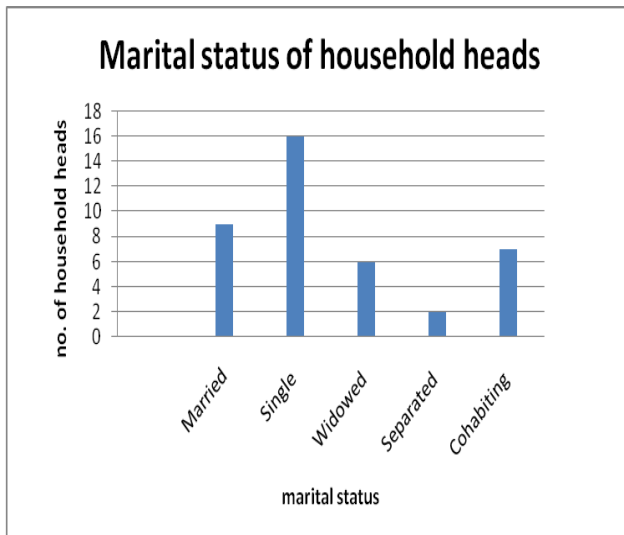
**Reconstituted matrifocal family**

Only 22 percent of household heads interviewed were married. The rest were single, widowed, co-habiting or separated. It is interesting that no one said they were divorced. Younger, single or co-habiting females were mainly found in the urban area. Their partners were often not the father of all their children. At times their own children are in the rural areas with grandparents or other kin. They could be raising the children of other kin i.e. siblings, cousins, aunts or uncles or children the partner had out of a previous relationship. In addition there may be other relatives of the couple who have migrated to the city in search of jobs or relatives who are ill and are being cared for by the household head.

### The conjugal nuclear family

The graph below shows that the nuclear conjugal family is a minority experience, as most of the household heads interviewed indicated that they were not married. It also supports earlier claims of high out-of-wedlock births, and that marriage is often not a precondition for having children or founding families. In this study the nuclear family of mother, father and dependent children applied in less than 10 percent of cases.

**Graph 5: Marital status of household heads**



The findings of this study about the transition to grandparent or elderly-headed households are consistent with findings from international studies reported by Barnett and Whiteside (2002 and 2006). They are also consistent with the findings on Namibia as reported by Sporton and Mosimane (2006). The study also confirms the role of the elderly in mostly female-headed households who carry the largest share of the OVC care burden, for the most frequently observed family form was the extended family missing the middle layer i.e. grandmother and a host of grandchildren, and even great grandchildren.

### **6.3.2 Effects of mortality on household composition**

#### **a) Size**

Although over ninety percent of households experienced some form of mortality, average household size remained large at 9.2 persons per household. This is much higher than the figure of 5.1 cited in the 2001 Population Census (2003) statistics. In this study rural households had an average household size of 12 persons, while the 2001 Census sets it at 5.7, and urban households at an average of 6 persons, compared to the 4.2 cited in the 2001 Census. These averages however mask big differences, for in the rural area household size ranged between 4 to 24, persons while in the urban area it ranged between 2 to 11 persons. The larger household size is consistent with Fuller and Van Zyl (2006) and Haludilu's (2005) findings that OVCs tend to live in larger households.

Both rural and urban household size showed a lot of fluidity as there was constant inward-outward migration due to labour migration, proximity to educational and job opportunities, illness, death, marriage, domestic violence and housing shortages in the urban area.

#### **b) Age and household composition**

On average households consisted of 6, 5 adults and 4, 5 children. On the surface it may seem to indicate a lower neontic dependency ratio. There is, however, a paradox since ninety three percent (56 out of 60) of household heads interviewed indicated that they had experienced adult mortality at least once, most families experienced multiple deaths in their families, and therefore household heads were caring for several non biological children. In the classical nuclear normative family lifecycle model cited by Harder (2002), a demographic transition occurs when the young adults leave home, become financially independent, marry and start their own families.

As families mature the bulk of the familial responsibilities begin to rest with the sandwich or middle layer.

In most of the rural families in this study this demographic transition is delayed. Elderly household heads raise their own children, then the next generation of grandchildren and sometimes great grandchildren. Given high levels of un- and under employment, adult members of the extended family remain dependent on the elderly household head. In one case the elderly cousin was also placed with the household head, because the younger members of his family who were supposed to care for him predeceased him. The peculiar family life cycle could also be as a result of patrilocal residential patterns, where adult children bring their wives and move into their fathers' homesteads. Their children then simply remain at these homesteads when the parents move out or die.

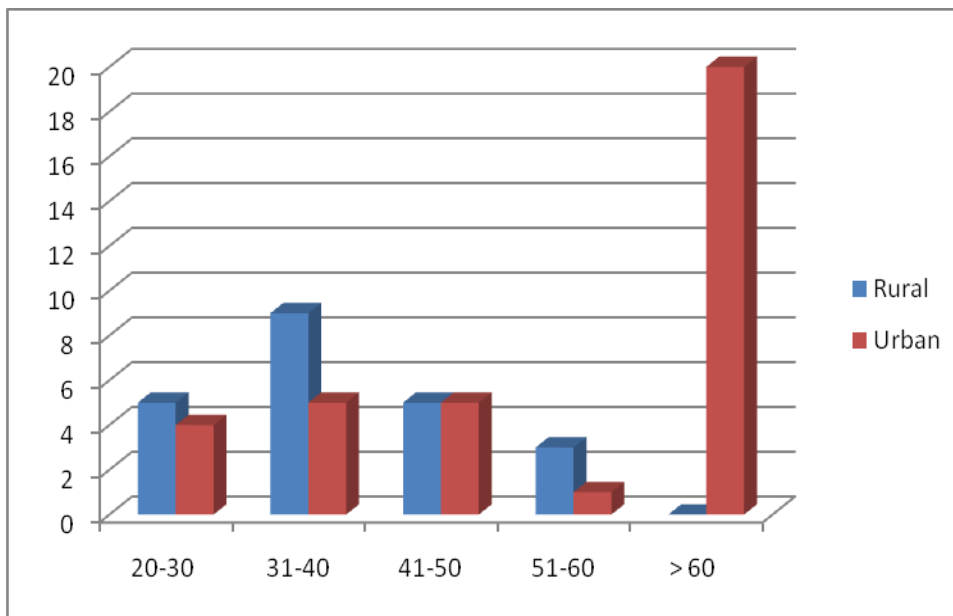
As mentioned before, although in most cases elderly female household heads are caring for orphaned grandchildren, often these grandchildren are also of reproductive age, so that the grandparents are also raising great grandchildren. Most households had a combination of orphans and children who were left there by biological parents who are still alive and working or living elsewhere.

One methodological problem encountered in the research was that caregivers had difficulty in distinguishing between own and biological children, because they often considered all who shared common bloodlines as their own. Grandmothers therefore often reported grandchildren as their own. Both in urban and rural areas it is not uncommon to find women caring for non biological children, sometimes while their own biological children are being cared for by another

relative in another household or even another region of the country. This is consistent with the proposition made by this researcher in Chapter 3, that parenthood is a social function that cannot simply be gleaned off biological connections. The social function of parenting is often separated from the biological function of genitor.

In the rural areas caregivers tended to be elderly females, while in the urban areas they were younger females. In most of the rural households the middle (sandwich) layer of adults was much smaller than older and younger people as shown in the graph below.

**Graph 6: Age of Caregivers**



**Age of household heads who are caregivers**

In the rural area the average number of adults per household was 5, 3 and in urban areas it was 4. Rural households were also caring for more children. The average rural household consisted of 5, 5 children while the average urban household contained 3, 6 children. On average

the rural household head was caring for three non-biological children. This is often more than the number of biological children in their care due to the fact that many of the household heads are elderly females past reproductive age. In the third phase of data collection, where large household were targeted, it emerged that individual household heads could be caring for up to 11 non-biological children.

### **c) Gender and household composition**

Women outnumber men in all the households. On average there were 3 adult females per household. In the urban area there were an average of 1.6 females per household, while, in rural areas there were an average of 4 adult females per household. In the urban area there was on average one adult male per household, and in the rural areas they were 3.2. In the urban area there were more male-headed households (42%) than in the rural area (25%). Fathers were conspicuously absent from the role of primary caregivers. Fifty three percent of orphans are primarily cared for by grandparents followed by aunts (26%), biological mothers (13%) stepmothers (4%) and uncles (4%). In 86 percent of cases where children are in the care of grandparents, it was a single grandmother.

### Reasons for caring for non biological children

*"I am raising four children. None of them are my own. God did not give me kids. One is my husband's child, one is my husband's grandchild and two are my sister's children. I took them in because my sister died and with the other two the mother's are in Ovamboland. I don't have any kids of my own."* S is a 44 year old domestic worker from Havana settlement in Windhoek.

*"I don't have any children of my own but I am raising two children. One is my sister's and the other my aunt's. I am the only one who could take them because their mother died and the grandmother is too old. It is a difficult burden, but I have no choice. I made a promise that I will look after the one when the mother was dying."* M is between 30-40 year old and an unemployed woman who lives in Havana with her boyfriend.

*"I am looking after my sister's child, but my four children are in the North. My sister is looking after them and they are helping her cultivate the land."* N single unemployed 41-50 years old female from Grysbok, Katutura

*"We are 24 people in the house and 16 of them are my grandchildren. They are the children of my sons and daughters who have died. I took them in, in the memory of my children who have died. Before they came we were ten, but two got sick of AIDS and died. Some of the children are actually my husband's children and his grandchildren."* 61-70 year old grandmother from Eenhana

*"I was given these three orphans to care for after their parents (my cousin) died, while five were born here of which four are orphans and one child's parents are still alive. They are the children of my sisters."* 32 year old woman from Onhuno in Ohangwena

*"I am caring for 7 children. 6 were born here and one came after the father died because the mother remarried."* 81 year old woman from Onaame in Ohangwena

*"These children were first staying with their parents at the cattle post. Then their mother died. The father remarried and sent them to me, I am the grandmother. He does not take any responsibility for them or support them because he has other children."* 72 year old woman from Onaame in Ohangwena who is taking care of 8 non biological children

*"These children were all born here in my house before their parents went to build their houses. Three children are orphan. Their parents died, while with twelve of them the parents are still alive."* 75 year old male from Omahata in Ohangwena



Some households face multiple forms of migration and multiple deaths. A common pattern of change in household composition starts with the initial migration of a male migrant worker who comes to Windhoek in search of work. At the time of migration he may leave behind a female partner with one or two children. He may then start new sexual relationships with other female partners in the city with whom he may have other kids, but regularly visits them and may or may not make cash transfers to the rural partner and her children. According to tradition the mother is responsible for feeding her children, and therefore it is not uncommon for women to accept that men do not have to support their children.

In some cases the female partner in the rural area may decide to join her male partner and leave the older children with extended family members like grandparents, uncles or aunts who raise them in the extended family. She may then have additional children in Windhoek, whom the couple raise in a quasi nuclear family. The children may visit rural siblings during school holidays or vice versa depending on the family finances. Those in the rural extended family may grow up with other cousins also being raised in that extended group whom they regard as brothers and sisters.

When the male falls ill, he may return to the rural area to be cared for by those who remained behind i.e. parents, siblings or children. He may also remain in the city due to the proximity to medical facilities. If he remains in the city, the partner may care for him. If she falls ill as well, they may split up and each return to their kin to be cared for by their respective natal families, while the children may be given to extended family members in the same or other households. Upon the death of parents the younger children are sent back to the rural areas to be cared for by grandparents, while older children could migrate to the urban areas in search of better

educational and job opportunities. If the man's other partners in the city also die, their children may be sent to their maternal or paternal grandparents in the rural areas. The couple may therefore have left a network of children strewn across households in different geographic areas. In some cases the children may be raised as siblings. In other instances they may know about the others' existence but not be in contact with them, and in other cases they may never have met.

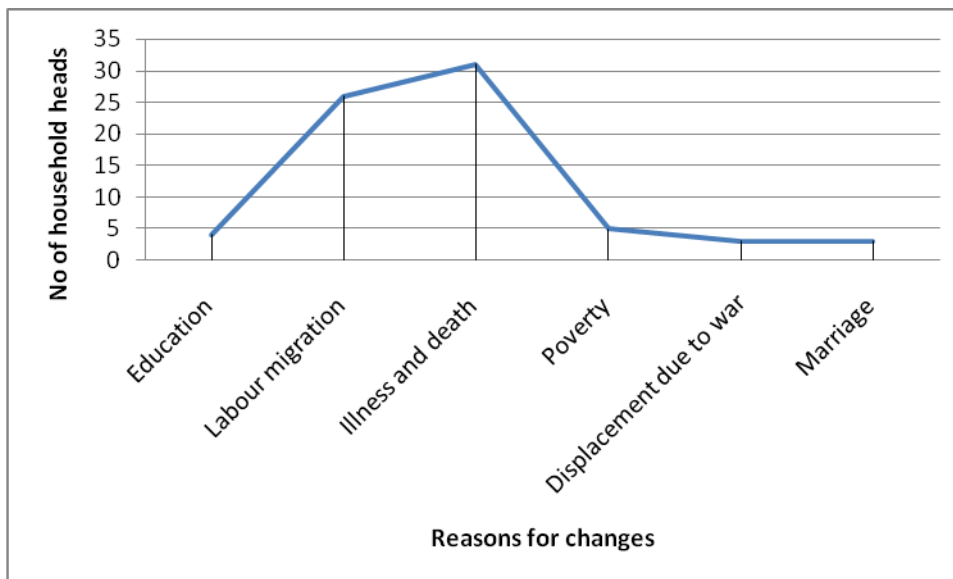
The evidence in this study shows that elderly grandmothers often look after the children her sons or daughters had with multiple partners. The children may know that they have half siblings elsewhere whom they have never met. It is also not uncommon for children to report that they did not have contact with their biological siblings or parents, because they did not know them or because they were living elsewhere and were only informed about the parents' death afterwards. In very large households a frequent response to the question of why the household head took in the non biological children was that they were born in that household and had been living in the household ever since, while the biological parent often left them there and moved elsewhere to work or to marry other partners.

The various forms of labour and AIDS related migration result in multiple fissions and reconfigurations. Children could be raised in both nuclear and extended families, by biological parents or other members of their kin. Children often come to regard primary caregivers within the extended family as their parents, rather than those who gave birth to them.

In the Ohangwena Region there is an additional dimension to migration, namely cross border migration to and from Angola. In addition to children and grandchildren dying of AIDS, elderly household heads also reported changes as a result the liberation struggle. Many from this

region joined the People’s Liberation Army of Namibia (PLAN) and died during the war. People of the two countries also share familial and cultural ties. There is also frequent movement of people between the two countries due to shared grazing areas that straddle the border. Angolans also cross into Namibia to use medical facilities. During the civil war in Angola, people on the Namibian side of the border housed refugees from Angola. Those who took in Angolans feared the legal ramifications. Even currently some of the Namibians interviewed revealed they had Angolans staying with them, but that these were only temporary arrangements in response to particular problems or hardships like food shortages.

**Graph 7: Most frequently cited reasons for changes in household composition**



### **Interaction between migration and HIV/AIDS in changing household composition**

*T is a 30-40 year old Silozi speaking woman. In 1996 she looked after her sick HIV positive sister until she died. At the time her husband was working as an insurance broker for a big insurance company and was making enough money to support the family. This meant that she did not have to work and therefore had the time to look after her sister. In 1998 her husband died. His family accused her of having bewitched him and claimed all his belongings including a car and death benefits that were paid out by the company. The company also reclaimed the company house they were living in. She had to move into the Kahimo squatter settlement in Rundu. At the time she had three small children and was forced to find ways of making a living. She started buying and selling fabric, but was still not making enough money to sustain her family. Her parents were too impoverished and she could not return to her parental home. In the year 2000 she decided to move to Windhoek where she rented a room inside a house in the Marula suburb of Katutura. She continued selling fabric and added cosmetics to her product range. She still could not make enough money to pay her children's school fees and the rent and therefore built her own shack in Okahandja Park.*

*While in Windhoek she met her current boyfriend who moved in with her and her children. She had three more children from him. Over the last three years two nephews have come to look for jobs in Windhoek. They stayed with her until they found their own accommodation. Her boyfriend's brother is still with them because he is still unemployed.*

*H is a 30-40 year old Oshiwambo speaking widow who lives in Okahandja Park. She migrated from northern Namibia to join her boyfriend and father of her children in 2000. She has three children in the North whom her aged mother cares for. The children are between the ages of 10-13 years. When she first came to Windhoek, she moved in with her boyfriend in Okuryangawa and*

*had two more children. In August 2006 her boyfriend died. Her boyfriend's brother and sister moved into the house with her and after a while they forced her out. She then moved to Okahandja Park to stay with her brother and his wife. The brother has stopped working because he has AIDS and is too sick to work. His wife sells traditional beer. Another brother, who works for the City Police visits over weekends and sees to most of their needs.*

*N is a 41-50 year old Oshikwanyama speaking woman from Grysbok in Windhoek. She has four children. Three (between ages of 17-21) are in the North because they were raised by her sister after she migrated to Windhoek on her own. The children are from two different fathers who have already died. Her children help her sister to cultivate the land and N has not seen them in three years because she has no money to visit the North. Her children do not wish to visit her because she is HIV positive. In 2006 her boyfriend of 15 years died of AIDS. They lived in a big house in Grysbok because her boyfriend sold beer and had a lot of money. By the time he died she had her fourth child. She could not make the home loan payments after his death and therefore lost the house. The family who bought the house took pity on her and allowed her to put up a shack in the backyard which she currently shares with her son and her sister's child.*

Most interviews in the urban area occurred in informal settlements with newly established households and relatively young household heads. The majority of household heads cited migration (62%) and illness and death (62%) as the primary reasons for changes in household composition. As cited before, some were single mothers who left children in the rural area because they were too poor to look after them in the urban area, or they sent them to the rural area after birth, because they could not afford to feed them. One household head was in the army

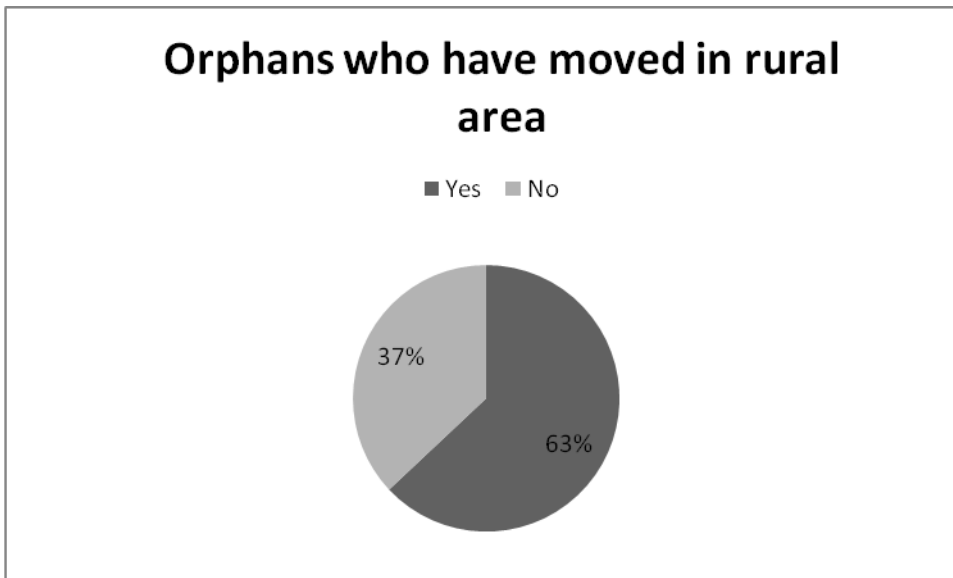
(Special Field Force) and had a daughter who had left the country to study in America, which accounted for a change in the household composition.

The majority of household heads in the rural area cited illness and death (100 percent) as a primary reason for changes in household composition. This was followed by labour migration (75%), war and resulting movements between Namibia and Angola (18, 8%), marriage (18, 8) and education (18, 8 %). Those who cited education were household heads who have taken in children of relatives because of their proximity to schools. Related kin in remote villages send their children to live with relatives who are closer to schools.

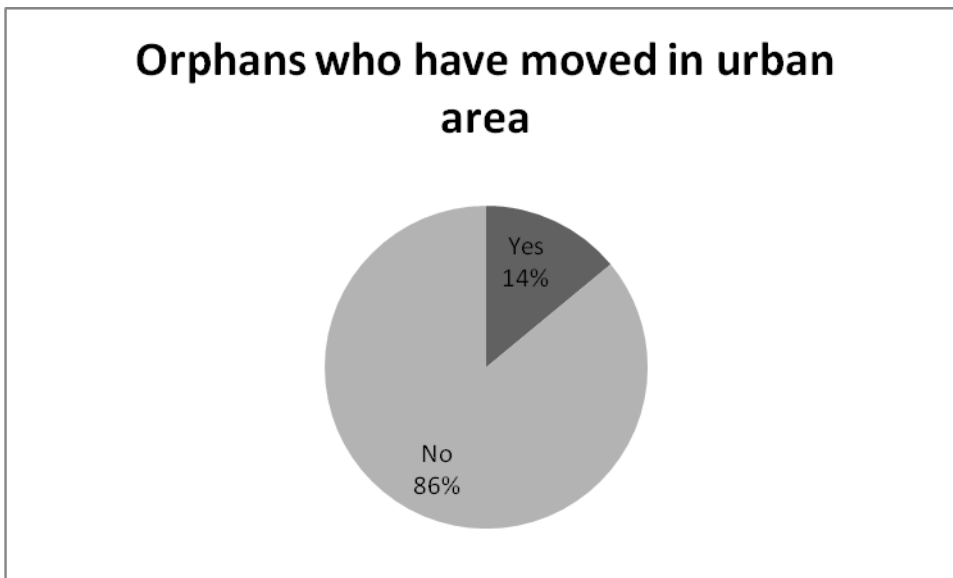
None of the household heads interviewed cited proximity to medical facilities as a reason for change in household composition, but the social workers and NGO staff interviewed at Engela reported that a lot of inter-familial conflict emerges around overcrowding at this location. Sick people from remote villages move in on relatives in rural towns because of the proximity to a hospital. They at times bring their children along to be cared for by the relatives while they receive treatment.

Forty nine percent of children interviewed indicated that they had moved from one household to another as a result of the illness or death of (a) parent(s). Orphans who are in the rural area are more likely to have moved than orphans in the urban area.

**Graph 8: Rural orphans who have moved from one household to another**



**Graph 9: Urban orphans who have moved from one household to another**



Double orphans formed the majority (42%) of orphans who moved to another house followed by maternal (29%) and paternal orphans (29%).

Only 8 percent of those who have moved did so from an urban to a rural area while 4 percent moved from a rural to an urban area. The majority moved within the Ohangwena Region, from the parental home to the grandparents, aunt or uncles. Most of those who did not move as a result of the death of a parent were already staying with their current caregivers (mainly grandparents) before the illness or death of parents. Fifty five percent of paternal orphans who did not move remained with their biological mothers. The remaining 45% either moved to a grandmother, aunt or uncle, despite the fact that the mother is still alive. Fathers appear to be absent from OVC care. Not a single maternal orphan reported the father as a primary caregiver. One indicated that while the grandmother was the primary caregiver, the father visited, but is unable to take care of his child because he had to work. Another OVC indicated that she went to live with her father after her mother's death, but when the father died, she moved to her grandmother.

The third phase of data collection was specifically undertaken to understand why some AIDS affected families were so big, despite the death of adult family members. In some cases adults also migrate as a result of AIDS mortality. Out of the 20 large households specifically targeted, all household heads raised non biological children linked to mortality. In 70 percent of the cases they had also taken in adults for the following reasons:

- The households could not sustain them.
- In one case a divorced woman was chased away by her husband.
- In two cases the households were dissolved, and the homestead abandoned. (In one case the actual structure was destroyed.)



- In two cases the caregivers of elderly adults died, and they were moved to a household that experienced mortality.
- In some cases the adults came to assist with child caring and agricultural activities.
- In one case the deceased husband's family seized the assets and chased away the widow and her children.

The linkages between changes in household composition and livelihood systems are clear. Mortality at times changes the economic structure of the family or household. The findings of this study support findings cited by Mullins (2006) that a loss in income or labour as a result of illness or mortality could lead to stress migration or the dissolution of household/family as an economic unit. In this study the situation was further aggravated by customary inheritance patterns, which strip widows and children from income and productive assets.

## **6.4 OVC Care Burden**

### **6.4.1 Primary Caregivers**

In this study it was mainly elderly household heads that were taking care of grandchildren, great grandchildren, children of sisters, brothers, the grandchildren of brothers and sisters or the children of cousins, children or children and grandchildren or the children their deceased or absent husbands had with co-wives. The Namibian government's orphan policy gives primacy to the extended family in the mitigation of the orphan crises.

HIV/AIDS often affects family clusters and families that are confronted with multiple AIDS deaths. At times the children are too many to be taken in by one household, and they are then

separated and given to different caregivers in the kinship group. Sixty percent of household heads interviewed indicated that the children they were caring for were separated from other siblings.

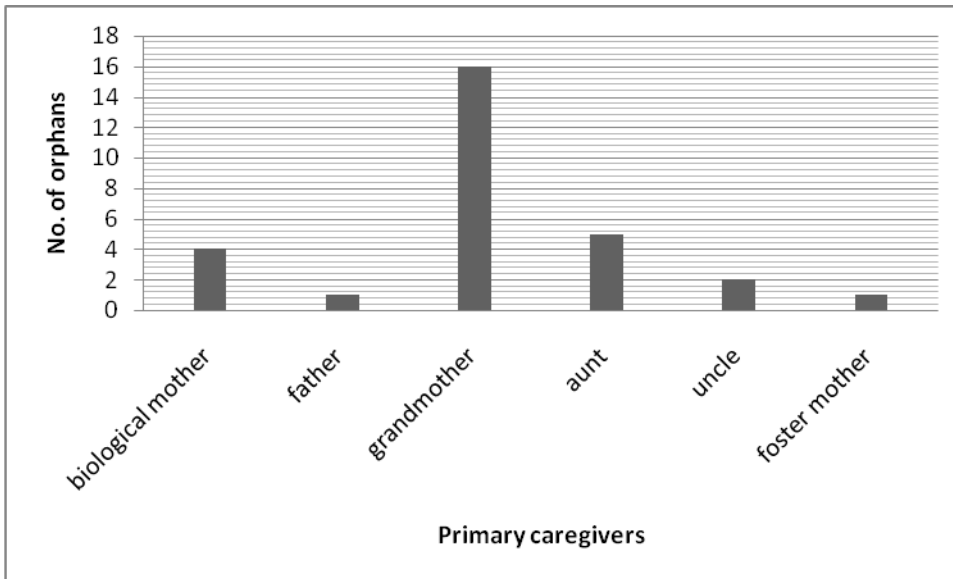
The most frequently cited reasons for the separation were:

- The person who was initially taking care of the children died, and they were divided up amongst households in the kinship group.
- Children have the same father but different mothers, and their maternal kin are caring for them.
- Some children have the same father but different mothers, and the father brought all his children to be cared for by his mother.
- Some mothers married other men, and the children who were born outside wedlock remained with grandparents to be raised with the mother's younger, unmarried siblings.
- Children were given to their fathers' relatives after the death of a mother or the maternal grandmother.
- They were too many to give to one caregiver, so they were separated after their parents' death.

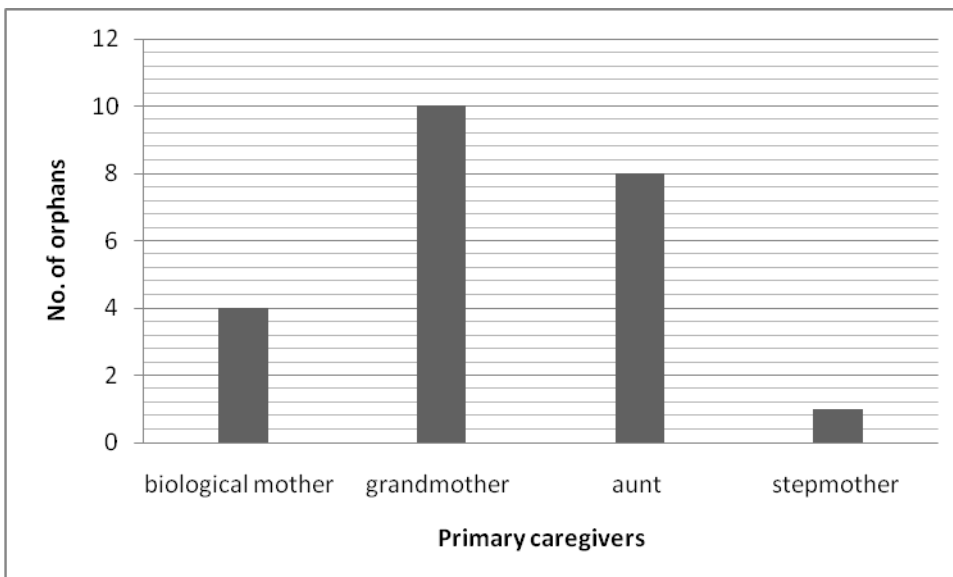
In certain instances the separation has resulted in loss of contact between siblings, and caregivers indicated that in certain instances the siblings do not know one another. As stated previously, some children have been with the grandparents since birth, particularly in cases where the mother migrated to the urban areas in search of employment or to pursue further studies, or when biological parents leave the home to marry or cohabit with other partners. It is not unusual that the grandmother lives in the rural homestead or urban household with a number of related grandchildren, who are either born to one mother but have different fathers or have one father but different mothers since many children are born outside marriage.

Seventy six percent of household heads were caring for non biological children. In the rural area the number was much higher than in the urban area, with 94 percent of household heads caring for non biological children compared to 63 percent in the urban area. There is normally a kinship relationship between caregiver and non-biological children as shown in Graphs 10 and 11.

**Graph 10: Primary caregivers of OVCs in rural area**



**Graph 11: Primary caregivers of OVCs in urban area**



These findings are consistent with other findings in southern Africa reported by Andrews et al. (2006) and UNICEF (2003) that the extended families primarily take in OVCs, and OVCs are not being rejected on a large scale. This study shows, in some instances the paternal kin, particularly paternal grandmothers cared for the children of their sons. This is contrary to the customs of matrilineal societies.

#### **6.4.2 Reasons why household heads took in OVCs**

Seventy nine percent of household heads gave kinship ties as the primary reason why they took in OVCs. Other important reasons cited were that children assist with agricultural activities and household chores. Often household heads felt compelled to take in OVCs because of familial obligations. Social workers reported a lot of conflict and resentment in families because of familial obligations and expectations foisted on caregivers from both the extended family and communities. Foster families are often overstretched and impoverished and feel the burden of extra responsibilities. Social workers also argue that this could lead to different forms of abuse inside the family. Despite this, 98 percent of children interviewed said they felt part of their caregivers' families. Eighty nine percent felt that their caregivers and foster families treated them well and the same as the other children in the family. Eleven percent reported some form of discrimination against them inside the family.

The general self perception of both the caregivers and OVCs was that they were part of the same family. OVCs cited the following reasons why they felt so:

- Blood relations
- Relations by marriage
- Felt part of the household and contributed towards household chores

- Felt love and wanted

International studies cited (Harvey, 2003, De Waal; Tumushabe, 2003; Mutangadura, 2005) show that OVCs may be adopted and integrated into the rural livelihood system either to compensate for lost adult labour or as a source of income in the form of bridewealth. This was difficult to verify in this study. Household heads admitted that children contributed towards domestic and agricultural labour, and some cited this as one of the reasons they took in OVCs, but this did not appear to be the primary motivation. Children are also socially expected to contribute towards domestic chores. Social workers did report the abuse of children and child labour as outlined later in this chapter, but the majority of household heads interviewed in this study did not give child labour as the primary reason why OVCs were taken in. Nor did the OVCs themselves cite it as reason

### **Reasons why household heads took in non-biological children**

*“Because their parents have died and there is no one to take care of them. I was forced to take them in; otherwise they would have been homeless. I have feelings of sympathy with them. When I look at them they remind me of their parents and the memory of my beloved daughters who have died. I keep them because they are the only marks that assure me that their parents did exist.”* 61-70 year old grandmother from Eenhana

*“They were homeless and had no one to stay with, and I am their grandmother. They are the people who are helping me now that I am getting old. They are doing everything, and I love them and want them to be with me.”* 61-70 year old grandmother from Eenhana

*“All are my relatives apart from the boy who is a non-relative. That is not a problem. I just take him as family because we have all been created by God and I believe he can help me. The six kids they are mine because they are my daughter’s and son’s children. I have to take them in and help them as well.”* 61-70 year old grandmother from Ekolola Village Ohangwena

*“They are my family. There was no one else to take care of this one. The mother said I should take care of her before she died. I made a promise to the mother. I have no choice. They are orphans, and I feel the burden but I have no choice.”* 30-40 year old aunt from Havana

*“The mother died and the father could not manage. He brought them to us, and then the father also died. It’s my husband’s brother’s children. I can’t leave them with others.”* 30-40 year old aunt from Havana

*“They are my sister’s children; therefore I am their mother.”* 41-50 year old aunt from Grysbok

### **OVC responses to the question of whether they feel part of their caregiver's family**

*"Yes I feel part of the family, and she treats me well. She always tells us to behave because her days are also numbered, and we don't know where the wind will blow us."* 12 year old double orphan. Caregiver is the grandmother.

*"Yes, because she is the sister of my mother, and she cares for me."* 9 year old maternal orphan. Caregiver is the aunt.

*"Yes, because she is my mother, and she brought me into the world."* 15 year old paternal orphan. Caregiver is the mother.

*"Yes, because she gave birth to my father."* 10 year old maternal orphan where the caregivers are the paternal grandmother and biological father

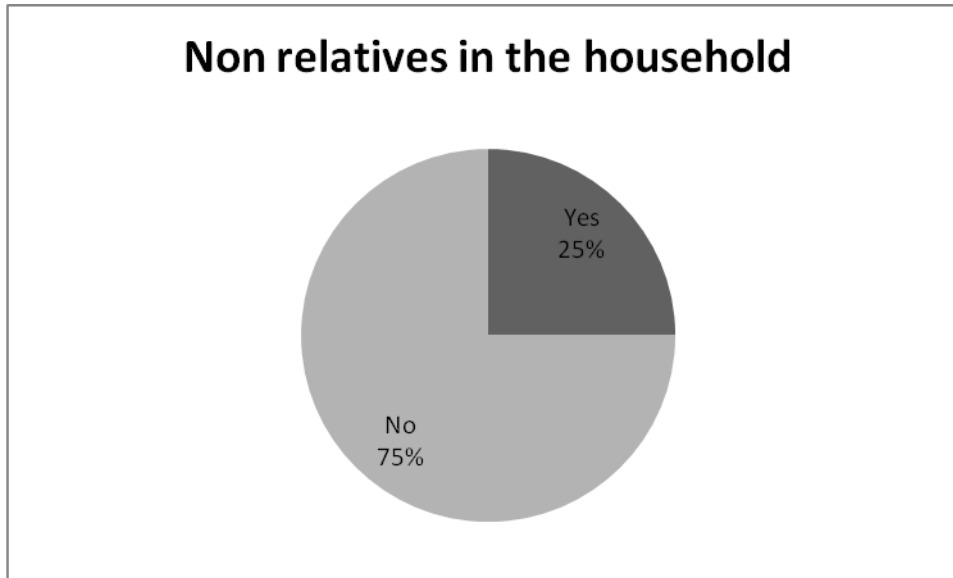
*"Yes, because she is my father's sister."* 12 year old paternal orphan. Caregiver is the paternal aunt

*"Yes, because it's my mother's sister and I love them all."* 9 year old double orphan. Caregiver is the maternal aunt.

## **6.5 Kinship and shared residence**

Only 25 percent of household heads indicated that they had non relatives in their households. The majority of households with non relatives were in the urban area. People take in non relatives for economic, cultural and humanitarian reasons. In the urban area, non kin adults in the household are mainly boarders/ lodgers who rent a room inside the house and thus supplement the family's income. They could also be temporary guests who have migrated to the urban area and are saving to set up their own households or shacks.

In the rural areas people take in non kin to assist with agricultural production like cattle grazing and crop cultivation, particularly during the harvest period. People also take in non kin who are their namesakes and become fictive relatives. There are those who simply took in vulnerable children in the neighbourhood or from other destitute groups, like San children, on humanitarian grounds.

**Graph 12: Number of non-relatives in household**

## 6.6 Role of the extended family in OVC care

Since so much emphasis is placed on the extended family, it was important to ascertain the role it plays in the OVC's support and care network. This was gauged by asking the children to list the persons from whom they receive certain types of support or care.

The results show that grandmothers carry most of the care and support burden. Children in the rural area had more kinship group members in their care and support networks than those in the urban area. This could indicate a weakening of kinship ties that accompanies urbanisation. The five OVCs who received support from the newspaper were cousins whose mothers died from AIDS. They felt that they had little support from the extended family and that the latter

discriminated against them because of the multiple deaths and therefore avoided them. In this particular case the extended family however assisted with the funeral costs.

## **6.7 OVC Supervision**

In addition to the care and support networks there was a need to see what type of adult supervision children had. Some families felt obliged/ forced to take in OVCs, which could lead to neglect and abuse. The findings show that most children had some form of adult supervision and at times different members of the family shared the supervision tasks, as they get permission for different things from different people. In the urban area only the five children supported by the newspaper indicated that they did not have any relatives in their support network. They are in a school hostel for most of the year, but visit the grandmother over weekends. It appears that the grandmother is only marginally involved in their care.

The gendered nature of caring reported in this study is consistent with international research findings reported by Harvey. In this study women made most of the decisions about childcare and supervision inside the home, but when it came to the children's engagement with others outside the home, men also sometimes became involved, for example in allowing children to play with other children or granting permission for them to travel as shown in the table below.



**Table 19: People children report to or get permission from (as a proxy for adult supervision)**

Person	Sick	Late from school	Permission to play with	Travel
Grandmother	19	24	16	19
Grandfather	-	-	4	5
Mother Stepmother	10	9	9	10
Father/ Stepfather	-	-	2	3
Aunt	16	13	14	13
Uncle	-	1	2	1
Sister	1	1	1	1
Teacher	6	-	-	-
Nobody	1	5	5	1
<b>Total</b>	<b>53</b>	<b>53</b>	<b>53</b>	<b>53</b>

Social workers were of the opinion that within the extended family it was mainly close relatives who supported OVCs. Some felt that in urban areas the extended family is reluctant to get involved due to time and financial constraints. High unemployment rates and the high incidence of poverty limit the support they can give. The costs of raising children are perceived to be higher in urban than in rural areas, since housing, food and educational costs are higher. Some expressed the opinion that the extended family is disintegrating; therefore the burden primarily rests with grandparents.

In the rural area some argued that historically the payment of bridewealth to the maternal kin was the reason maternal grandmothers took on the bulk of the caring burden. Bridewealth payments by paternal kin were deemed sufficient to care for orphans after the death of a parent or

both parents. However, since a large percentage of children are born outside marriage, it is most unlikely that bridewealth has been paid. One social worker familiar with Kwanyama culture argued that the role of the paternal kin is limited to their participation in big ceremonies like marriage. This study however found that, contrary to tradition, some of the OVCs and household heads indicated that paternal grandparents were the primary caregivers of some OVCs.

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**Table 20: OVC Support Network- Urban Area**

no	food	fees	clothes	books	homewor	Problem at	Problem ds	sad	Money
1	grandmother	grandmother	grandmother	school	grandmoth	teacher	grandmother	grandmothe	grandmother
2	grandmother	GRN grant	grandmother	school	sister	teacher	grandmother	sister	grandmother
3	aunt	aunt	aunt	school	sister	teacher	sister	aunt	aunt
4	aunt	aunt	aunt	school	aunt	teacher	aunt	aunt	aunt
5	stepmother	aunt	aunt	school	stepmothe	stepmother	stepmother	stepmother	aunt
6	aunt	KWID	KWID	school	sister	teacher	aunt	aunt	aunt
7	aunt	GRN grant	KWID	school	aunt	nobody	teacher	aunt	aunt
8	aunt	KWID	KWID	school	aunt	aunt	aunt	aunt	aunt
9	GRN grant	aunt	aunt	school	sister	aunt	sister	aunt	aunt
10	aunt	N?A	aunt	N/A	N/A	N/A	aunt	aunt	aunt
11	mother	mother	KWID	school	mother	teacher	mother	mother	mother
12	aunt	aunt	KWID	school	aunt	teacher	teacher /aunt	aunt	aunt
13	grandmother	grandmother	KWID	school	aunt	teacher	andmother	nobody	grandmother
14	newspaper	newspaper	newspaper	school	nobody	nobody	teacher	nobody	nobody
15	newspaper	newspaper	newspaper	school	nobody	teacher	teacher	nobody	nobody
16	newspaper	newspaper	newspaper	school	nobody	hostel matron	hostel	nobody	nobody
17	newspaper	newspaper	newspaper	school	sister	hostel matron	hostel matron	nobody	nobody
18	newspaper	newspaper	newspaper	school	nobody	teacher	teacher	nobody	nobody
19	mother	N/A	mother	N/A	N/A	N/A	mother	mother	mother
20	mother	mother	mother	school	sister	teacher	mother	sister	mother
21	newspaper	newspaper	newspaper	school	nobody	teacher	teacher	teacher	nobody
22	mother	mother	mother	school	nobody	teacher	mother	nobody	mother
23	stepmother	N/A	stepmother	N/A	N/A	N/A	stepmother	nobody	nobody

## **6.8 Child Headed Households**

During fieldwork for this study only three Child Headed Households (CHHs), or more precisely, Youth Headed Households, were found. In all cases the household heads were young women between 20-28 years old. The children in the household were a mixture of siblings, half siblings, nieces and nephews since the parents of the household heads and other siblings had died, leaving behind dependent children. In one case the 22 year old household head and her three adult siblings were raising 6 children. Only one of the six children attended school because they could not afford school fees and uniforms to send the others. Despite the stigma and ridicule meted out by members of the community, a local chief assisted them and provided some form of adult supervision and guidance.

Key informants confirmed that Child Headed Households existed, but were not widespread. In the main they were headed by children over the age of 18 who act as the caregivers to younger siblings. NGO staff rely on community based volunteers to report cases of CHH for assistance in their communities. Just a few cases have been reported thus far. This however does not give a complete picture, for although the NRCS for example has a large network of community based volunteers with wide outreach in communities starved of services and assistance programmes, they do not reach all communities due to great distances between villages, lack of transport and inhospitable terrain. Government social workers complain of similar problems. In addition to high case loads, they have to travel long distances to reach clients in remote and sparsely populated areas, resulting in limitations on the number of people they can reach.

Often extended family members take the younger children after the funeral, while older children (normally over 18) choose to remain in the parental home to guard cattle and other property from being expropriated by the extended family. In these cases headmen or community members come to their assistance. There is also evidence of household dissolution when all the children and cattle are moved to other homesteads. One social worker reported a case where all adults had died and where the homestead was completely abandoned.

The biggest concern about CHH is the impact household responsibilities have on their education. To social workers and NGO programme staff, keeping children from HIV affected families in school is a primary concern, and most of their assistance programmes are geared towards payment of school fees and uniforms. In the urban area there is the concern that CHH's lose their homes as a result of non payment of municipal bills or leave home as a result of hunger and poverty to become street children. Since no street children were interviewed in this study, this could not be verified.

## **6.9 Alternative and institutional care arrangements**

Often rural household heads could not conceptualise what an orphanage was, because there are no equivalents in their areas, and they equated it with school hostels. Twenty two percent of household heads indicated that they would send OVCs to non relatives if they could provide better care for them, and 32 percent said that they would send them to orphanages. Those who said that they would consider sending children away cited the strain on resources and the best interest of the child as the primary reasons they would do so.

Those who said that they would not send the children away offered the following reasons for their decision:

- Blood ties and strong emotional bonds prevent them from giving children to others.
- Fear that the children will come to harm or will suffer
- Fear that the children may be exposed to bad influences
- Children assisted them with agricultural and domestic work
- Because they have made promises to the parents that they would raise the children and they do not wish to break these promises
- They have to report to the extended family and cannot make decisions about the children's welfare without consultation with the extended family.

### **Responses to sending children to orphanages**

*"Yes, it will be better for us because we don't have alternatives, and they are going to be helped."* 22-30 female head of a CHH near Engela who cares for 6 children

*"Yes, if they are going to have enough food and if there is education"* 41-50 year old female farmer from Engela area who cares for 7 children

*"Yes, if there is education and they get everything for free."* 61-70 year old grandmother of Ekolola village who cares for 4 children

*"Yes, I will only give them away if they are going to a good situation, get education and good behaviour. I can't give them if they are going to suffer."* 61- 70 year old grandmother from Okongo area who cares for 7 children

*"Yes, because things are changing and schools are expensive, and these expenditures will increase."* 30-40 year old female farmer from Omulamba Village who cares for 4 children

*"Yes, if there is free education or something good I can send them to, but I have to make sure there are good people. I don't want them to suffer and some people discriminate against the orphans."* 61-70 year old grandmother from Eenhana who cares for 12 children

*"Yes, I will send the kids if I have information about the people who are going to be there with this kid and if they are going there to be educated. If they are not going to do that, why should I send them there? I will only give them up if there is a law that demands that all orphans must go to orphanages."* 61-70 year old grandmother from Ekolola village who is caring for 7 children

## **6.10 Economic effects of illness and death**

As reported throughout this chapter, the findings of this study are consistent with the findings on the economic impacts of AIDS related morbidity and mortality reported by a number of researchers cited in Chapter 3, such as Mutangadura and Webb (1999); Harvey (2003); Mullins (2006); Barnett and Whiteside (2006); Andrews et al. (2006); Von Liere (2002); De Waal (2006); De Waal and Tumushabe (2003). The most frequently reported impacts relate to the loss of income, loss of labour, loss of productivity, food insecurity and increased expenditure as a result of illness and death.

### **6.10.1 Income**

In the urban households where one or more members have formal employment, families are better able to mitigate the impact of AIDS related illness or mortality. In the urban areas most household heads interviewed were females between the ages of 22 and 50 who did not qualify for government pensions and therefore had to make a living through petty trading or casual labour, as well as cash or kind remittances from partners and relatives. Most people reported that cash income was immediately spent on pressing necessities like buying pre-paid water meter cards, food, and fuel and school fees.

However 71 percent of household heads interviewed in the urban area described themselves as unemployed and lamented the lack of job opportunities. Most relied on petty trading to obtain paltry incomes like selling sweets, paraffin, kapana (roasted meat) or fire wood. Those who are able to engage in higher yielding income generating activities like sewing lack the inputs like material to consistently derive income from such activities. Women are particularly

vulnerable, and therefore some resort to taking on boyfriends as a survival strategy. As stated before some send their children to the rural areas simply because they are not able to feed them. This is consistent with the findings of international studies reported by Mutangadura and Webb that show that one response to AIDS mortality is for families to send children away to reduce the dependency burden.

An interesting question that emerged out of the research is how to put numbers to income and expenditure when household heads interviewed could not give clear figures themselves. It also raised an important question about how census and other household income statistics are generated. Midway through the research the researcher had to abandon attempts to enumerate the concept of total monthly or annual household income. Given the diverse and often unreliable income sources, most people did not keep record of their income simply because they lived from hand to mouth. They were often not in a position to compute average monthly or annual incomes which they got and spent on a daily basis. Only a few informants with permanent monthly incomes from wages, salaries and pensions could provide some account of monetary income although this was not always exact, because total household income included both regular and irregular remittances as well as cash and kind transfers. Despite that the fact that people were not able to give exact figures, they could report decreases in income sources as a result of illness and mortality.

Those interviewed in the rural area were mainly elderly female-household heads that made a living through a combination of subsistence farming, government pension transfers or cash and in kind remittances. They firstly had great difficulty in placing monetary value on their agricultural produce, which was mainly used for their own consumption or sometimes transferred



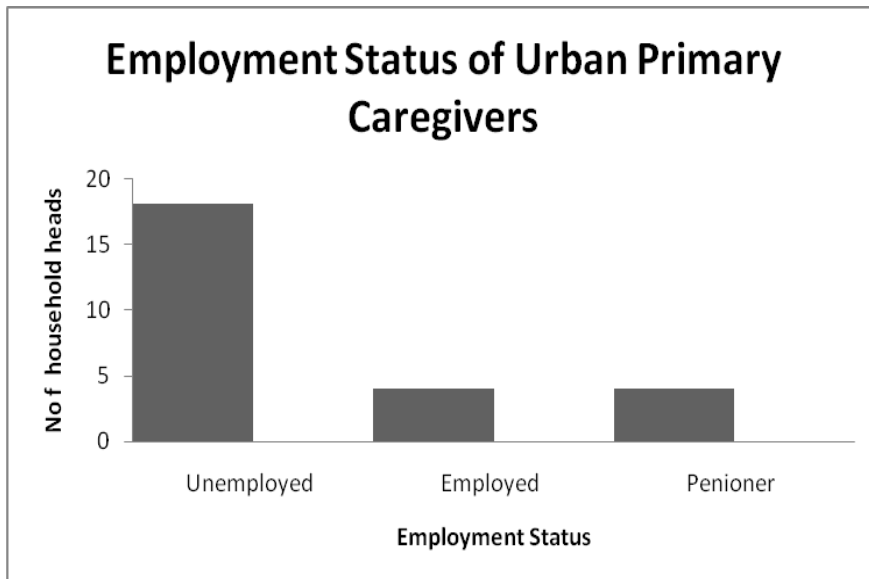
to needy households in their kinship group or in their village. Although more rural households reported the receipt of cash remittances than urban households, these remittances were irregular in frequency and value.

### **6.10.2 Income sources**

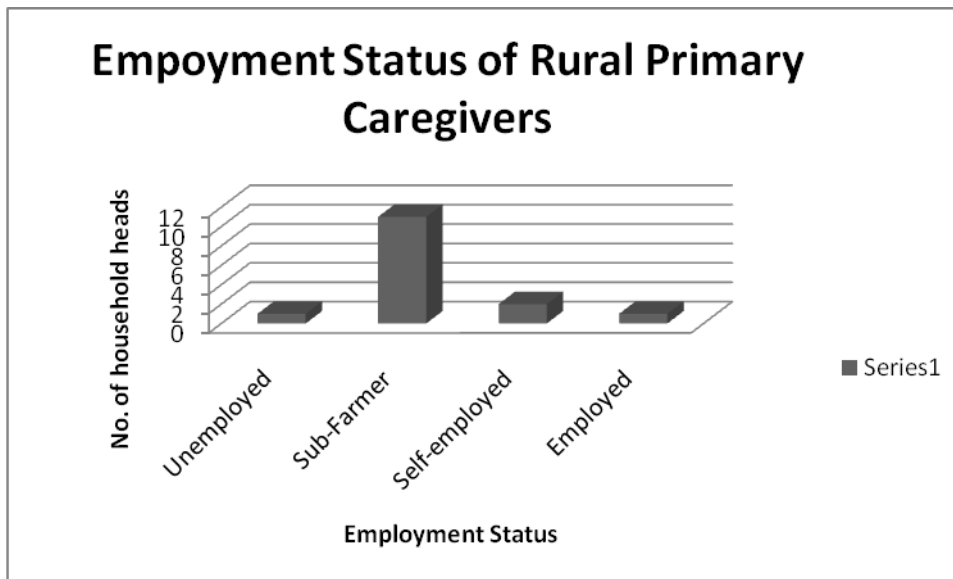
In rural areas most households depended on subsistence farming, social grants like age pensions and remittances. A few people reported the sale of beer, soft drinks and kapana as income sources.

In the urban area most female household heads interviewed classified themselves as unemployed, but generated income through wages from partners, sales of products, pensions for the elderly members of the household, foster or child maintenance grants. Petty trading like the sale of kapana, beer, paraffin or wood made up most of the income generated from sales. Those who cited wages as an income source mainly had household members employed as domestic workers, cleaners or security guards. Total household income is normally generated through a combination of the mentioned sources.

**Graph 13: Employment status of primary caregivers in urban area**



**Graph 14: Employment status of primary caregivers in rural area**



### 6.10.3 Dependency ratios

In Chapter 2 there is a discussion on how dependency ratios are calculated. If one takes the classic definitions of children under the age of fifteen years to define the neontic or green

dependency, ratios do not appear that high. This study found that although there were relatively high numbers of adults in some households, they were not making a big economic contribution to the material reproduction of the family unit since they were mainly unemployed or underemployed. For example in the Havana informal settlement the researcher encountered a family of eight persons. Four were adults and four children. They all relied on the grandmother's wages. She is in her late fifties, not old enough to receive a government pension, but does domestic work for N\$ 800.00 per month. In addition the family received a government child support grant of N\$200.00 per month. From this example it is clear that the classic age definition of dependency does not suffice, because it does not take into account dependent adults who do not contribute towards household income as a result of unemployment or ill health. Since this research was done amongst families in poor urban and rural communities, unemployment rates were very high as indicated in graph 13.

Patterns of gender division are also still clearly discernable. Certain forms of economic activities are still performed by women even when men are un- or underemployed.

**Example of the gender division of labour**

Y is between 22-30 years old. She and her boyfriend live in a shack in Okahandja Park with their five children. Both of them and one child are HIV positive. When we visited their house on a Saturday afternoon, she was doing laundry while the children were playing around her. The baby was lying on a broken mattress near her. Her boyfriend was preparing for our visit in a makeshift shower almost on the dirt road that leads to their shack. Her boyfriend passed grade 12 and expressed great frustration with his inability to find a job. Their only source of income comes from the sale of firewood which Y collects in the bushes on the outskirts of the settlement. Once a man followed her and tried to rape her. She struggled with him and managed to run away. He shot at her and the bullet went right through her leg. Despite the danger she still continues to collect the firewood while her boyfriend stays at home.

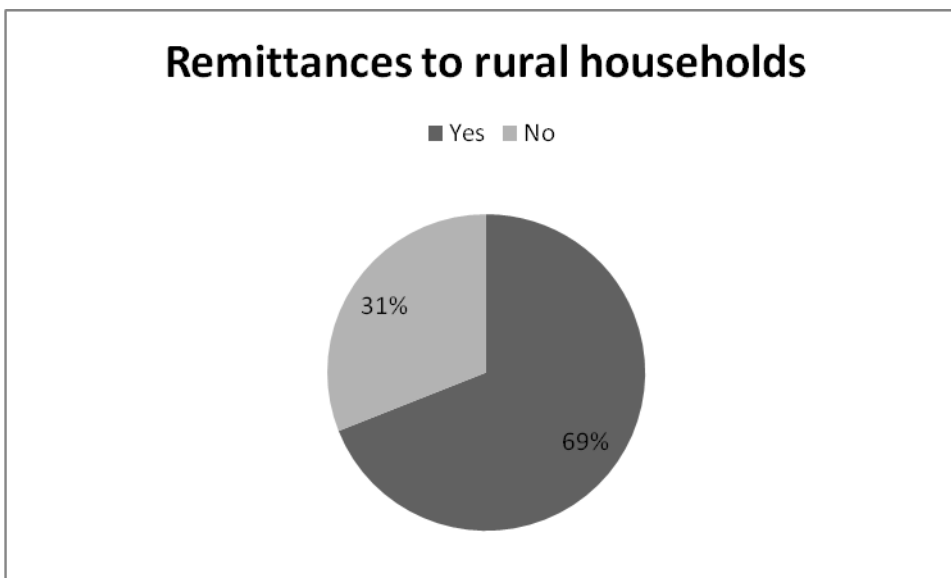
**6.10.4 Remittances**

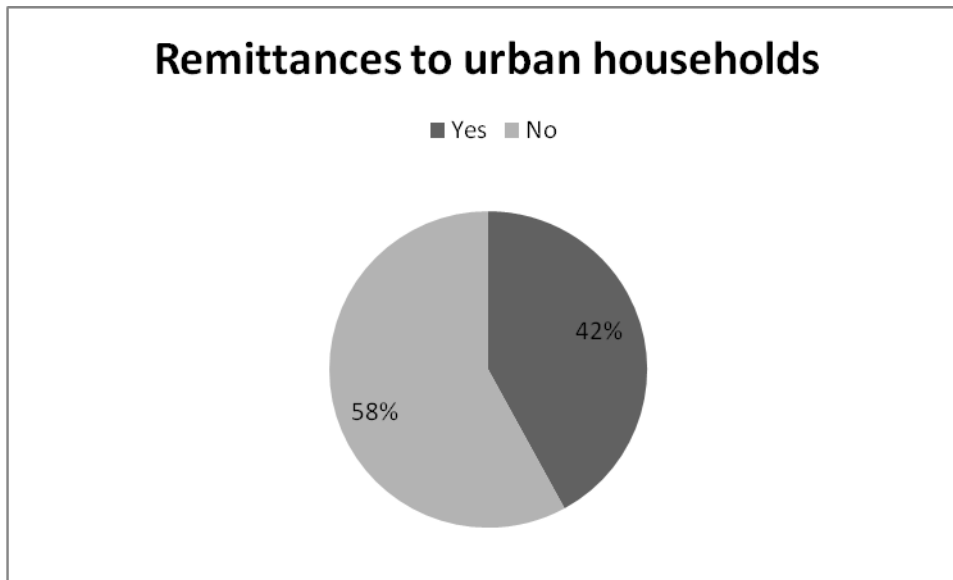
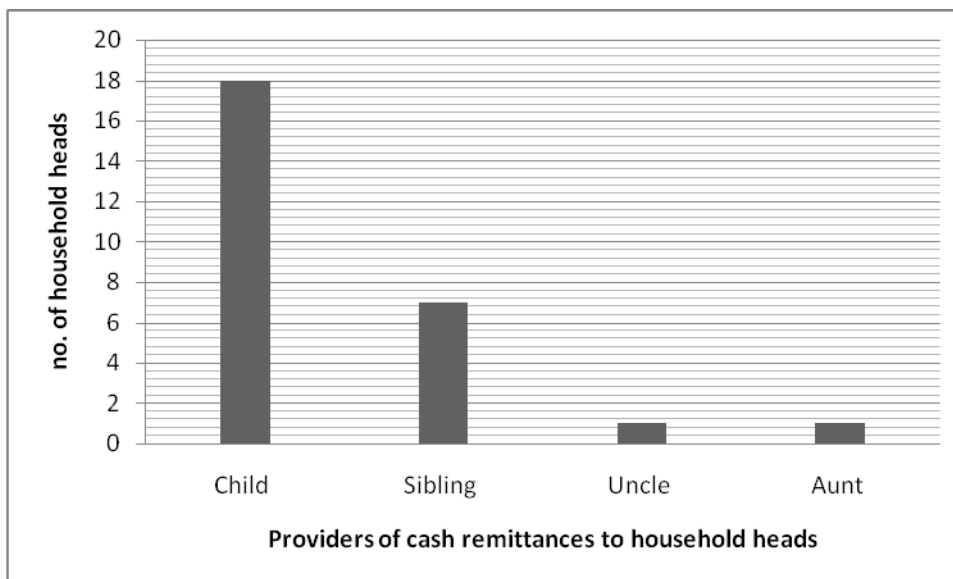
Remittances play an important resource pooling role and are often used as a criterion in defining family boundaries. The evidence shows that rural households rely on transfers from the wage sector. Remittances come from male and female workers. Sixty nine percent of rural households reported that they received cash remittances from relatives who did not reside in their homes permanently, compared to forty two percent of urban households. The main sources of remittances are adult children, and siblings, i.e. brothers and sisters. Those who do not receive remittances from relatives reported a loss of contact with relatives or the fact that relatives are themselves too impoverished as the key reasons for not getting financial support from them.

Children interviewed also reported receiving some financial assistance from relatives other than the caregivers. Besides cash there are also in kind transfers between households in the form of clothing, toiletries, uniforms and food. Although AIDS affected households in this study were generally poor, they still transferred food to other households. Despite the fact that rural households showed a lower percentage receipt of cash transfers, some do benefit from intra-household food transfers from rural to urban households. Food transfers are made to other rural households, but also urban households in the kinship group. In addition rural households also take over responsibility for children from vulnerable urban households who are sent to the rural areas because their parents can't feed them in the urban areas.

From the data presented it is clear that both household heads caring for orphans and orphans themselves receive support from the extended family in varying degrees. If one accepts resource pooling as a marker of family structures, then there is evidence that extended family systems still operate in Namibian society and form part of OVCs social security net.

**Graph 15: Cash remittances to rural households**

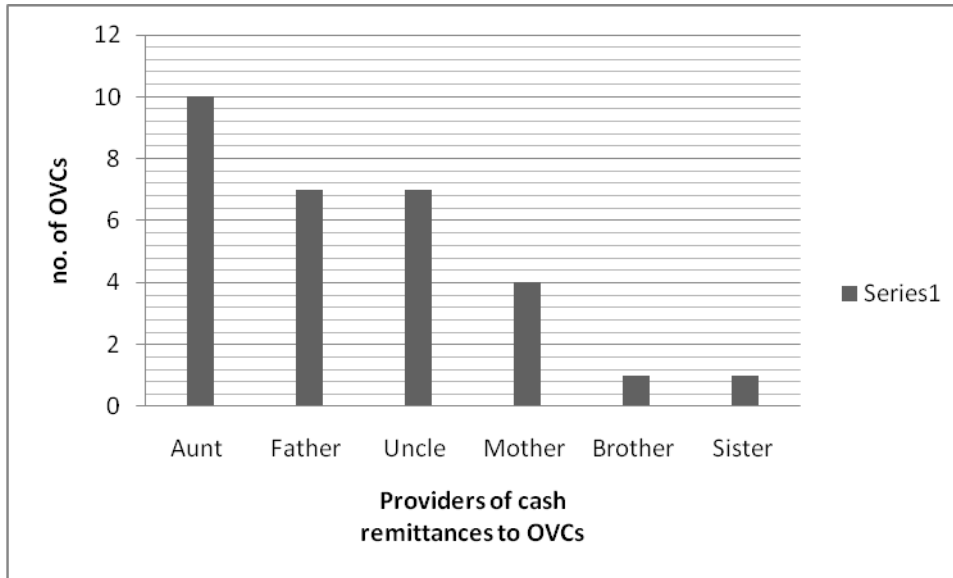


**Graph 16: Cash remittances to urban households****Graph 17: Providers of cash remittances to household heads**

From Graph 17 it is clear that the adult and working children of household heads are the primary providers of cash remittances in the case of older household heads. In the case of younger household heads, it comes from siblings, aunts, uncles and other relatives.

## Financial Assistance to OVCs

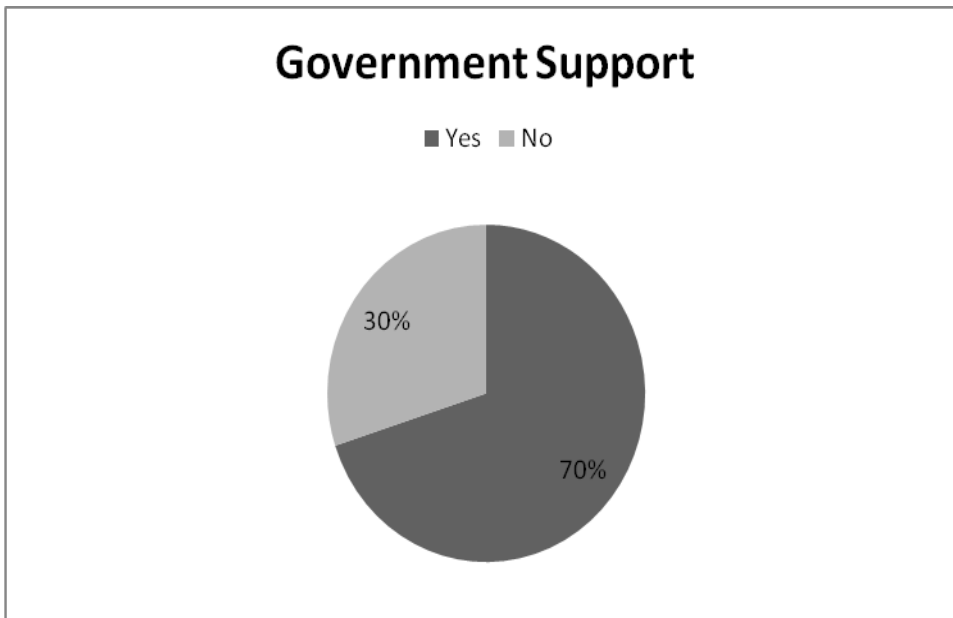
**Graph 18: Providers of cash remittances to OVCs**



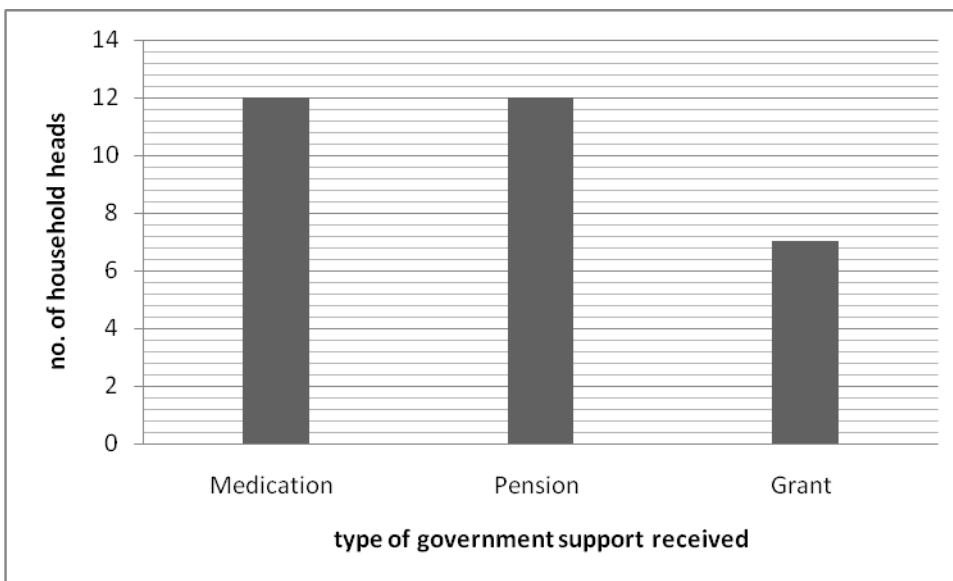
### 6.10.5 Government social transfers

Seventy percent of household heads indicated that they received some support from government. The support comes in the form of medical services to people who are ill or who require ARV treatment, followed by old age pensions and grants.

**Graph 19: Government support to households that have taken in OVCs**



**Graph 20: Type of government support**



Social workers and community workers report a low uptake of social grants and that these grants often do not reach those who need it most. Seventeen percent of children in the urban area and ten percent of children in the rural area indicated that they are government grant recipients.



Social workers and NGO project staff cited the following reasons for the low uptake of government grants.

### **Reasons for low uptake of social grants other than old age pension**

#### **a) Lack of national documents**

Many children do not have the birth certificates required to lodge grant applications. Some births were never registered, and some birth certificates got lost or destroyed. Some children moved between caregivers and cannot locate their birth certificates, because they got misplaced between the different households. Those who have been orphaned have difficulty obtaining the parents' death certificates. Sometimes widows refuse to give death certificates to children born out of other relationships, because they do not wish to acknowledge the property and inheritance entitlements of these children.

#### **b) Bureaucratic impediments**

Child maintenance and foster care grants go through lengthy screening procedures. There is also a lack of social workers and judicial officers to screen applicants. This results in long waiting periods. PLWA who are unable to work have difficulty obtaining grants. Their health status has to be verified by a doctor specifically appointed by government for this purpose. In certain regions there is only one doctor who has to deal with all the applications for that region. In addition people cannot always afford the transport costs to reach the doctor. Grant payments can also be suspended once a person's condition improves as a result of ARV treatment and he/she is no longer considered disabled.

#### **c) Low levels of literacy amongst primary caregivers**

Many elderly caregivers do not speak English and have difficulty accessing information about the benefits they could apply for. Some NGO workers argue that it is often more educated,

affluent and well informed relatives who are able to negotiate the cumbersome bureaucracy and are therefore able access the grants, rather than the largely illiterate aged caregivers.

**d) High travel costs to reach government offices**

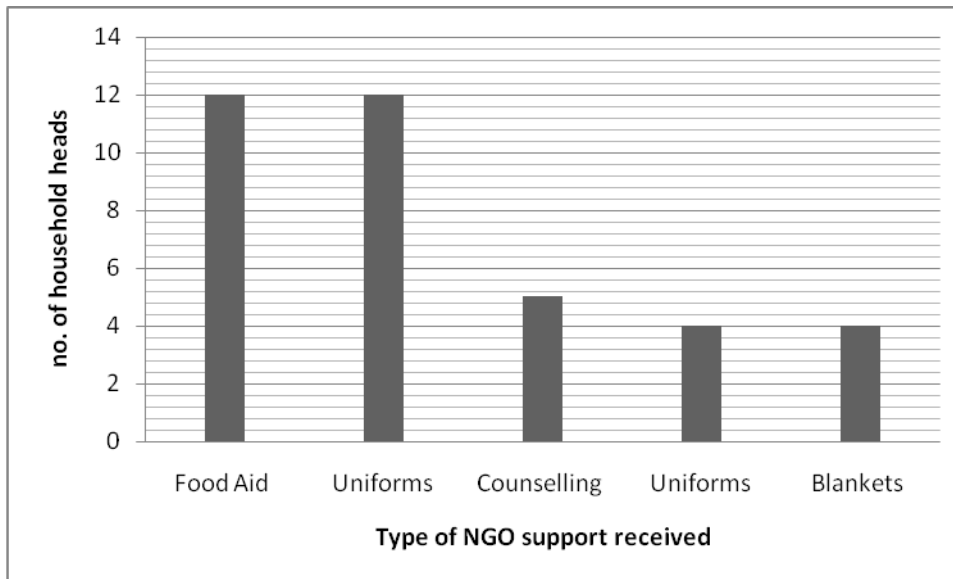
Despite government's decentralisation efforts, services still do not reach people in the remote rural areas. In the Ohangwena Region there were numerous complaints about the distances people have to travel to lodge grant applications at regional government offices. Elderly people at times cannot undertake these trips, because they are not fit enough, or because they lack the money to cover the travel costs.

**e) Duplication and abuse of benefits**

Social workers and NGO staff working with HIV and AIDS affected families constantly referred to the lack of monitoring systems to measure the efficacy and efficiency of programmes. They cited numerous examples of fraudulent acquisition and misuse of social grants. In certain cases caregivers access grants without it benefiting the children in whose names they are claimed. In some cases the person who claims the benefits is not the actual caregiver, for example a father, mother, uncle or aunt claims the benefits, and this is concealed from the grandmother who is the actual caregiver. Once the grants have been secured, children are palmed off to other relatives, often maternal grandmothers.

### **6.10.6 Support from NGOs and CBOs**

Most of the households visited are clients of the NRCS and KWID and therefore received some sort of support from NGOs. Graph 22 below depicts the main services received from NGOs.

**Graph 21: Assistance from NGOs**

Due to a lack of funds, community based volunteers and NGO programme staff acknowledged that they could only help a few. They also lamented the lack of a national database to ensure that the resources go to those who need it most and to eliminate abuse, as some caregivers receive benefits from different NGOs at the expense of others.

### 6.10.7 Expenditure

Ninety percent of household heads reported an increase in expenditure as a result of illness and death. The most common expenditure items reported were:

- Transport to hospitals during illness
- Medication
- Additional food for sick people
- Transportation of deceased person's remains for burial
- Funeral expenses like coffins and cattle for slaughter

- Payment of gravestones

In most cases it is customary for the extended family members to carry some of the funeral expenses. In one instance the household head reported assistance from Lirongo Eparo, who bought the coffin and paid for the food at the funeral. In another case a Catholic AIDS Action volunteer reported that volunteers at times buy food for the wake from the small stipends they receive. Namibia Red Cross Society volunteers reported that their organisation offers counselling as well as material assistance in the form of coffins and food to bereaved families. Some families go into debt to cover additional expenditure, and some reported that they were still busy paying off the debts incurred as a result of illness and death. Very few people could provide figures that could approximate the monetary value of the additional expenditure they incurred, because they failed to keep records, and because they received cash and in kind contributions from different sources.

#### **6.10.8 Other economic effects**

The impoverishment experienced by families affected by AIDS mortality leads to greater stratification between them and families who are not affected. This was constantly echoed by key informants. Social workers were of the opinion that death causes an economic gap that cannot be filled by elderly grandparents or government transfers since the value of these transfers are low and because of the multiple impediments affected families have to overcome to access grants and other social welfare transfers.

Twenty seven out of fifty three (51%) children interviewed reported adverse economic effects as a result of the death of (a) parent(s). The most common changes cited were the lack of

income to buy food, pay school fees and buy clothes. Children were also concerned that the impoverishment they experience as a result of the death of parents has become the basis for discrimination, stratification, differentiation and stigma. They also lamented the missed opportunities that could have arisen if their parents were alive to support them.

One household head from Otaukonjele Village described social stratification and stigma arising from their impoverishment as follows:

*“The community members laugh at us because we don’t have anything. We are poor. Sometimes they tease us and ask what we will eat. They say that our millet is still fresh and asked who will dry it so that we can have our dinner. They think what happened to us will not happen to them, but it is not our fault that we are like this.”*

### **Changes reported by OVCs as a result of parents’ death**

*“It has changed my life. My foster mother cannot provide for all my needs. My classmates all have school bags, but when I ask my foster mother, she tells me that she does not have money.”*  
Twelve year old double orphan

*“My mom used to buy me a soccer ball. Now my talent is fading because I don’t have a ball anymore.”* Twelve year old maternal orphans

*“Yes, they tell me that I used to wear nice clothes. Now I don’t wear them anymore.”*  
Nine year old maternal orphan

*“At home people treat me well, but at school it is different. They laugh at me and say that I did not apply lotion to my body so I am poor.”* Seventeen year old double orphan

In the rural areas of Ohangwena the most frequently cited economic impact of AIDS related adult mortality by household heads were:

### **Decline in available labour**

*“Our farm work went down. We do not have the energy to do the work of those who have died. They were young”.* Female Household Head, Engela

### **Loss of remittances**

*“He was working on a farm and would send us money to buy food and toiletries, and now nobody can help us.”* Female Household Head, Otaukondjele Village

*“A lot has changed in the family because they (those who died) were all adults and worked and brought bread into the house. Now they are gone and left a lot of kids. It’s painful. I have to be mother and father.”* Pensioner, Okongo

*“We are now suffering because my kids helped with the payment of school fees. Now it’s hard because I have a lot of kids to look after.”* Female Farmer, Okongo

### **Loss of other forms of income**

*“The deceased was a business man who had bars and the one who paid the school fees of the children. I still remember how he slaughtered cattle for Christmas. Now it’s just a day like any other.”* Pensioner, Eenhana

*“Yes the woman who died bought my toiletries, clothes and other needs. She also paid the workers who helped me on the farm.”* Pensioner, Omulamba Village

### **Loss in productivity and food production as a result of loss of labour**

Some have lost jobs as a result of their illness despite the non discrimination provisions of Namibia’s labour Act and HIV and AIDS policies. One woman interviewed in the Okahandja Park settlement reported that she was sacked by Ramatex, a big, multi-national textile company, because of her HIV status and recurring illness.

Some are desperate for jobs and do not want to live off charity and handouts but are not able to get jobs. Some have called for the introduction of a government grant for PLWA or the

introduction of the Basic Income Grant (BIG) to offset the humiliating levels of poverty they endure.

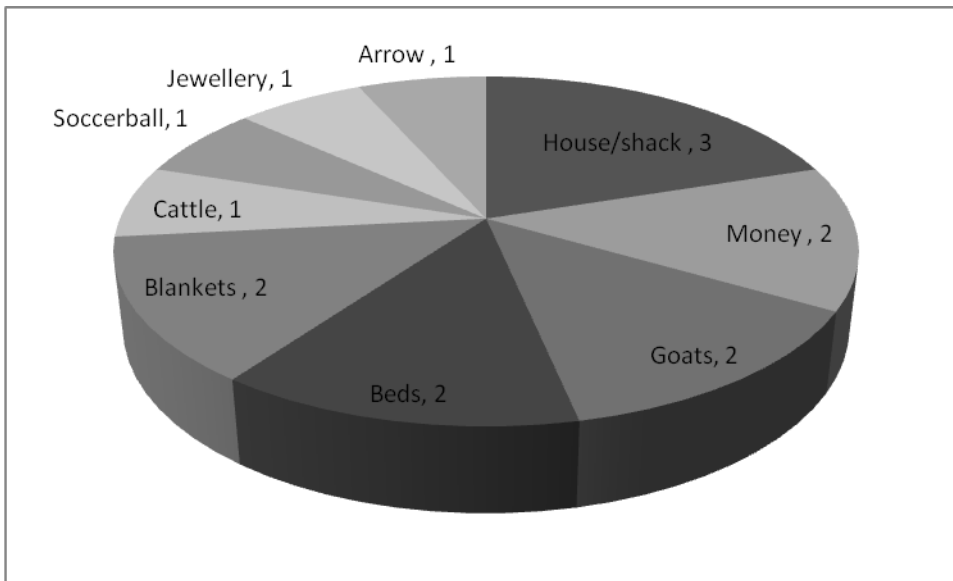
#### **6.10.9 Inheritance and the dispossession of women and children**

Current inheritance practises cast doubt on the idealised supportive, extended African family system. Despite legislation to prevent the dispossession of widows and children, the findings of this study indicate that the practice continues unabated. Only certain forms of personal property are at times transferred from parents to children. In most cases wealth producing property like cattle and land rights are inherited by the parents and siblings of the deceased. Dispossession is not limited to rural, agricultural-based families. In both the rural and urban areas there were constant references to property being appropriated by the relatives of the deceased at the expense of widows and children. This includes pension and death payouts by the Government Institutions Pension Fund (GIPF) or other insurance companies, houses, cars, furniture, other household items, jewellery and clothing. Besides outright dispossession, there is also a problem of the fraudulent appropriation of death benefits by relatives who foster children for the sole purpose of claiming the death benefits or property.

Only thirty percent of orphans interviewed indicated that they inherited something from the parent or parents who have died. Of those who inherited something from a deceased parent, 69 percent were girls. Boys therefore seem less likely to inherit. This may seem at odds with the literature cited in Chapters 2, 3 and 4 which assumes patriarchal inheritance systems in which men inherit property from the matrilineage. However, as reported by Lebert, it is the oldest surviving male in the kinship group who normally inherits the property. This may explain why young children and more particularly young boys inherited so little, if anything at all. From this study it

is clear that girls mainly inherited small, personal and non wealth producing property. Very few inherited money or other types of wealth producing property. Often the children were too young at the time of their parents' death to know who inherited the property. In two cases children inherited items like beds and blankets, but were unable to collect their inheritance because the parents lived or died in another location that they were unable to reach.

**Graph 22: Types of items inherited by children**



### **Children's responses to who inherited their parents' property**

- *“I was very young and I can't even remember the memorial ceremony or the funeral. I have not even seen my parent's graves and tombstones. I have only heard about it. No one has told what has happened.”*
- *“I got two goats and a bed. My father's family took his clothes since I can't fit into his clothes and they took his cattle.”*
- *“I got nothing. My grandmother took the clothes and the suitcases.”*
- *“I got nothing. My aunt took the bags, clothes, chickens, goats and many things.”*
- *“Nothing, I have no idea who inherited my father's car. I only heard that he had a car.”*



- *“Nothing, I was only informed that father was dead after two years.”*
- *“I got nothing. My grandmother inherited things like pots, clothes, and she took me with her.”*
- *“I was given a suitcase after my mother died, but it is still at my father’s place. Later I was informed that it was stolen. Apart from that I did not get anything. I can’t recall anything apart from the money I will get when I turn 21.”*
- *“I got nothing. My aunt, my mother’s sister, took the things.”*
- *“I got a blanket. My aunt took the other things.”*

- *“My aunt took all the things.”*
- *“Yes, we got the zinc shack. Other relatives took the clothes.”*
- *“I got nothing. My father’s clan took everything.”*

The disinheritance of widows and children was corroborated by the results of interviews with household heads. Eighty two percent of household heads confirmed that the orphans in their care did not inherit anything from their deceased parent/s. Like the children interviewed, many could not say who inherited the property the parents may have owned. In some cases they indicated that it was the brothers and sisters of the deceased. Since interviews were conducted prior to the Child Status Act coming into effect. Orphans who were born out of wedlock were not legally or customarily entitled to a deceased parent’s property.

Numerous stories about the disinheritance of women and children were recounted. Often the accusations of witchcraft were invoked to justify the dispossession. In some instances the women were stripped of every asset including the house they and their children were living in. In the urban area caregivers often reported that the deceased was young and unemployed and too

impoverished to leave any significant forms of property to their children. Two cases demonstrate the poverty faced by the affected families. The mother of the deceased inherited a bed, but the shack they are living in is too small, so they had to put the bed on the roof in the hope that they would extend the house in future. In the other case the deceased was working on a grape farm in Noordoewer and came to Windhoek ill and was cared for by the household head until he died. The family, however, was too poor to make the trip to Noordoewer to recover his belongings.

There seem to be a lack of succession planning on the part of parents. Key informants argue that many Namibian cultures do not condone speaking about death, particularly to children. There is a belief that to talk about death is to invite it into one's home. To discuss the death of parents with their surviving children is an even greater taboo, and in some cultures regarded as extremely cruel. Social workers and NGO programme staff also argue that there is still a great deal of denial about HIV and AIDS. PLWA often do not accept their HIV status or do not wish to face their possible mortality. They often hope that they will somehow survive it. Some feel that will making is for rich people and consequently do not make wills. Others do not want to betray their kinship group by making wills contrary to custom, and they die knowing that their wives and children will most likely be left empty handed.

### Household heads responses to whether the OVCs in their care inherited anything

*“My children did not inherit anything. My boyfriend’s family came from the North and took everything after the funeral. He was a taxi driver, so they took his car, clothes, radio and watch. We managed to build this brick house with the help of the Shackdwellers Federation. Now they want to take the zinc shack we lived in before. At the moment I am renting it to people who pay me N\$200.00 p/m for it. My boyfriend’s family said when they come to Windhoek again they will dismantle the shack and take the zinc with them. My daughter and I are both HIV positive and sometimes there is nothing to eat, but we have to take our ARVs.”* A 30-40 year old mother of two from Okahandja Park

*“No the children and I did not inherit anything. My boyfriend was working for the NDF and his family took everything, also the pension payout.”* 22-30 year old mother of two from Havana

*“The children did not inherit anything. I don’t know, but the place where the mother of the orphan died is very far, and we could not afford to go there. She gave me this kid when she was still alive. I must raise the child, because the mother of the child was my sister.”* 61- 70 year old woman who looks after seven non biological children in Ekolola Village in the Ohangwena Region

*“Yes, one inherited a donkey from his mother but never got it. There was really nothing to inherit.”* A 30-40 year old widow from Ohaihana Village in the Ohangwena Region

*“Three of the orphans got inheritance. They get N\$450.00 from the GIPF every month. I don’t know who inherited the other things.”* A 71-80 year old grandmother from Onaanda Village in the Ohangwena Region

Disinheritance increases the poverty of women and children. Social workers and NGO workers reported cases where women were already disinherited before the death of a partner or spouse. Often the male hides his HIV positive status from his female partner. Once she discovers that she is HIV positive and reports it to the male, he becomes abusive, accuses her of infecting him and evicts her from the house. Some are then forced to return to their parental homes, live with other members of their families, migrate from rural areas to the squatter camps or move from more affluent suburbs into the squatter camps.

### **Other forms of asset stripping**

There are also other forms of asset stripping associated with the death of breadwinners. NGO and social workers cited the foreclosure on homes for non payment of municipal services as a primary form of asset stripping. In urban areas the loss of a breadwinner often means that widows and children cannot pay their municipal service bills. The municipality then auctions off the houses in order to recover the outstanding bills, leaving the HIV affected families homeless. There were cases of bank foreclosures. In the one incident the pension payout was used to cover the outstanding bond payments and the working adult children of the widow could settle the difference. In another incident the woman lost the house and was forced to move into a shack at the back of the property which the boyfriend initially owned, because the new owners took pity on her.

The other form of disinheritance is by the caregivers themselves who claim the inheritance and death benefits on behalf of the children and then use them on themselves. In some instances spouses of the deceased parents prevent biological children from other partners from claiming the benefits by not handing over or even destroying death certificates. Social workers and NGO

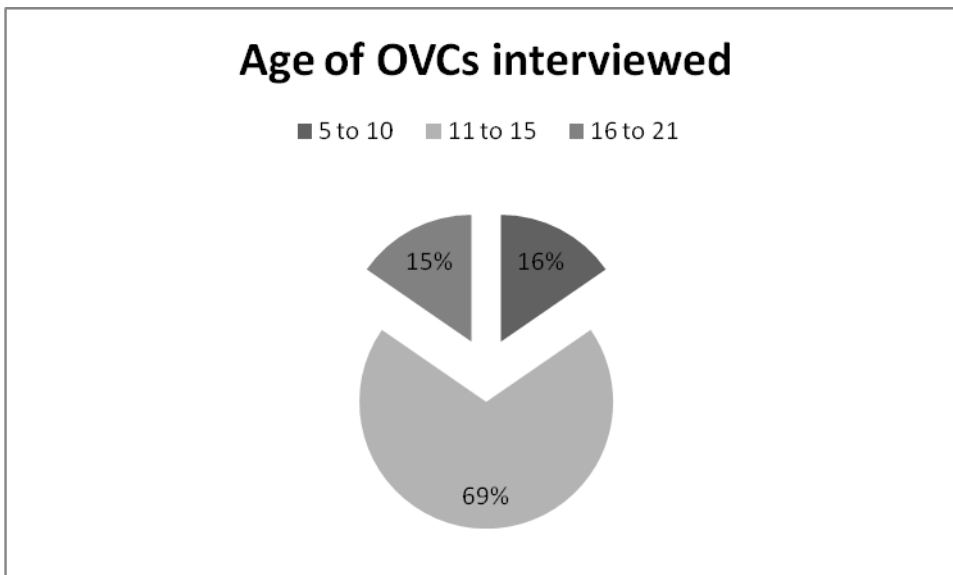
volunteers also gave reports of stepparents claiming benefits and leaving the biological children without anything.

## 6.11 OVC response to adult morbidity and mortality

### Demographic characteristics of children interviewed

It is difficult to ascertain the effects of orphanhood on younger children, because the method of direct questioning is not an appropriate form of data collection with young children. Many cannot articulate their experiences, and some are too young to remember the circumstances of their parents' death or departure. Most of the children interviewed were double orphans. In many cases the father may still be alive, but the children have never known their fathers, or they do not know how to contact them. Often the children are not fully informed about their parents' deaths. Some were staying with a grandmother or relatives at the time of a parent's death, and often they did not see their parents for long periods of time.

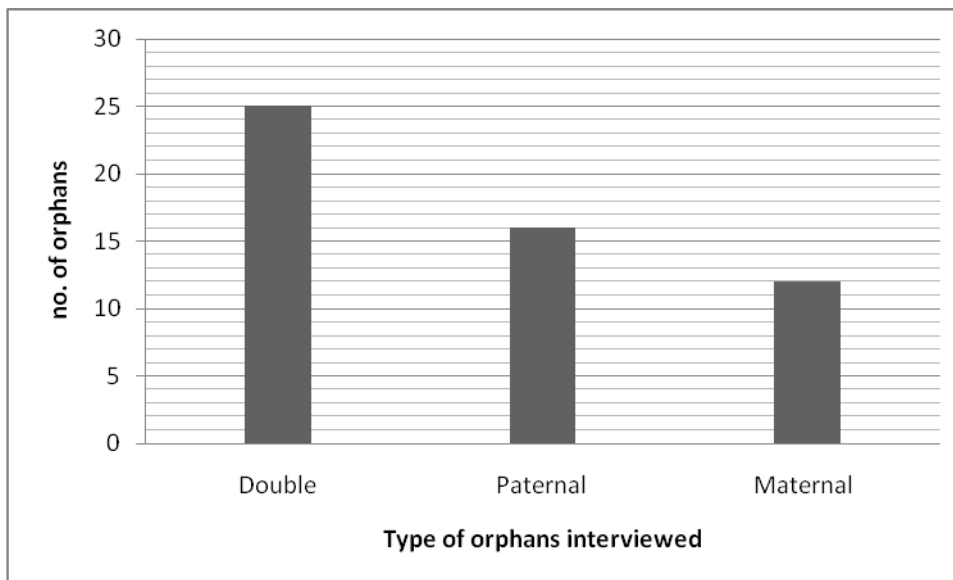
**Graph 23: Age of OVCs interviewed**



### Type of orphan

While most children interviewed stated that they were double orphans, others who classified themselves as paternal or even maternal orphans often lived with other caregivers because the surviving parent is living elsewhere. Maternal orphans often did not have contact with the surviving father, who either could not cope with raising the child or remarried and therefore brought the child to the caregiver.

**Graph 24: Type of OVCs interviewed**



Forty seven percent of OVCs interviewed were double orphans, 30 percent were paternal orphans and 23 percent were maternal orphans. The fact that double orphans are over represented in this study may be because they are needier than children who still have a parent, and therefore the caregivers came to the NGO that facilitated the interviews.

### **Orphans responses to how they experienced their parents' illnesses or deaths**

*"I did not know my parents and don't know what caused their death."* 12 year old double orphan (Ohangwena Region)

*"I was still a baby so I can't recall."* 9 year old maternal orphan (Ohangwena Region)

*"I only heard that he was my father, but I never saw him during his illness."* 8 year old paternal orphan (Ohangwena Region)

*"My parents were very sick at the time when I was very young. I cannot really remember what happened."* 7 year old maternal orphan (Ohangwena Region)

*"I never knew anything about my father's death because I have never seen my father."* 16 year old paternal orphan (Ohangwena Region)

*"My mother slept long and then she died."* 12 year old maternal orphan (Khomas Region)

*"I really can't explain. I was too small."* 13 year old double orphan (Khomas Region)

*"I was not living with my mother when she died. I was living with my stepmother."* 13 year old maternal orphan (Khomas Region)

### **Cause of death of parents**

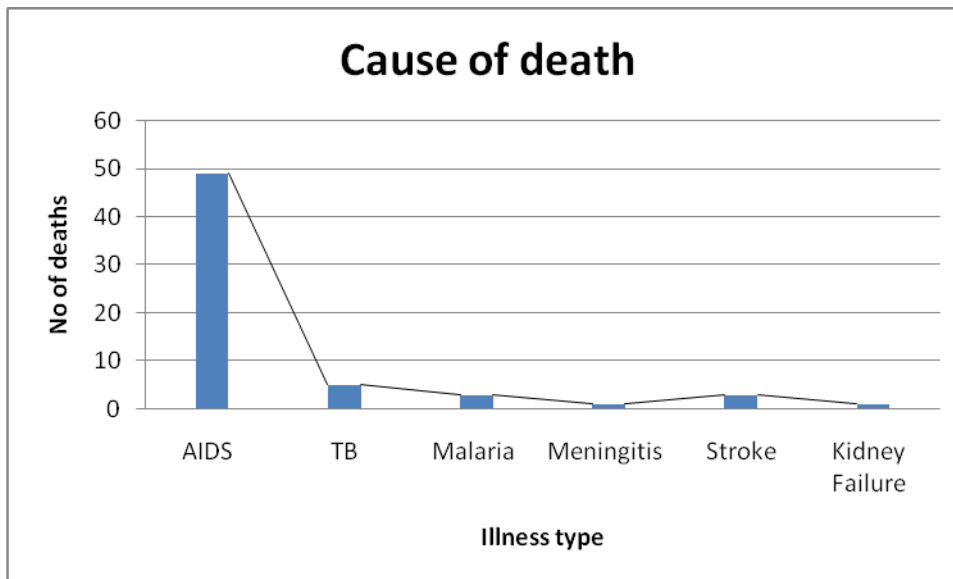
While this research was undertaken to assess the effects of AIDS related adult mortality on family structures, it was often not so easy to determine the actual causes of death and whether changes in family structures are caused by AIDS related mortality, or whether the adult death had other causes.

Representatives of NGOs like the NRCS and KWID argued that they do not make a distinction, because AIDS is a main cause of death, and many OVCs experience vulnerability and social exclusion in the same way, irrespective of what caused their parents'/caregivers' deaths. They argue that to make distinctions would be another form of discrimination. Others who receive funds for HIV and AIDS related work argue that donors dedicate funds specifically for AIDS

induced orphanhood and vulnerability, and therefore they are forced to make a distinction between AIDS orphans and other vulnerable children.

In this study most adult deaths were a result of AIDS. Some household heads interviewed were uncertain about the cause of death, and others indicated causes like TB or malaria that could or could not be HIV related, given the high co-infection rates between HIV and TB. This could have lead to the under reporting of AIDS related mortality.

**Graph 25: Cause of death of household member**



Time and again responses indicated uncertainty about the cause of death of a family member. Those interviewed in the Khomas Region were more open and ready to admit that AIDS was the cause of death than those in the Ohangwena Region. This could perhaps be an indication that the social stigma associated with AIDS may be stronger in the Ohangwena Region.



### Household heads' responses to the cause of death of family members

*“My husband died and five of my kids. My husband died of a stroke, the kids I can't remember. They were not sick.”* Widow and mother (Ohangwena Region)

*“Eight of my children died, I can't say that it is AIDS, but these days when people die it is because of AIDS.”* Mother (Ohangwena Region).

*“ We were all living in the same house with our different mothers. They were six sisters and five died. Every year we buried one. Then the others would look after us. My mother died in 2003, two aunts died in 2004, one in 2005 and one in 2006. Some of our families helped us with the funerals.”* 15 year old maternal orphan (Khomas Region)

*“He died after a long illness. Perhaps it was AIDS.”* Widow (Ohangwena Region)

### 6.12 Effects of adult deaths on children

Responses to the questions on the effects of adult mortality on children were very mixed. Some children and their caregivers felt that there was no or minimal impact, because the children were not raised by the biological parent/s who died. To others it caused major changes because their families disintegrated completely. To others the effects were more economic than emotional, because they were living with other relatives, for example grandparents, but their parents provided the income to cover food, clothes and education. Generally the inability to buy sufficient food and pay school fees and uniforms were the most common negative results attributed to adult mortality by both caregivers and OVCs interviewed.

Although some children grew up with grandparents and never lived with their biological parents, they experienced trauma because of the death of the parent/s because of the secrecy and lack of information they received from elders regarding their parents' condition. This left them with feelings of resentment.

Children interviewed in the urban area were more likely to say that their parents' deaths did not affect them that much because they were already living with their caregivers before the death, and, as previously stated, they were also less likely to have moved from one household to the next after the death of a parent. Those who spoke of the changes mainly referred to the fact that they were left hungry, and that they had no food because of their parents' deaths. So the most significant effect reported was the income gap.

### **OVCS' responses to how they experienced their parents' deaths**

*"I did not know my parents and I don't know what caused their death. It changed my life because my foster mother does not provide me with all my needs. My classmates all have school bags, but when I ask my foster mother she says she does not have money."* 12 year old double orphan - Ohangwena Region

*"I did not know him. It was a bad experience since I never got to see him, and don't even know what the good and bad things are that he has done for me."* 16 year old paternal orphan - Ohangwena Region

*"I only heard he was my father, but I never saw him during his illness. Now my grandmother sends me to the cattle post to look after the cattle."* 8 year old paternal orphan - Ohangwena Region

*"My mother was in a critical condition, and then they called me to go to her. At the time she had said something about the feeling that death was coming her way. My mom used to buy me soccer balls, and now my talent is fading because I don't have a ball anymore."* 12 year old maternal orphan - Ohangwena Region

*"My mother was sick and only death could save her from her pain. She was always crying because of the pain, and she had small pimple like measles on her body. Since her death I don't take food to school anymore, and my clothes are getting old. There is nobody to buy me new ones."* 15 year old double orphan - Ohangwena Region

*"No, I never knew my mother. They left me so young. It is hard to grow up when you don't know what a mother's love is."* 12 year old maternal orphan - Ohangwena Region

*"I only know about my mother's illness, but not about my father's, because at the time I was staying very far away from him and no one wanted to take me there. I did not even attend my father's funeral because there was no money."* 9 year old double orphan - Ohangwena Region

*“Yes, especially my father’s death because I used to live with my father until his death, and therefore it affected me badly. He used to pay my school fees. Now it takes time to settle my problems. My mother’s death did not affect me much, because I was not staying with her, but to lose a parent is a difficult thing. I never heard about her illness. I only learnt about her death afterwards.”* 17 year old double orphan - Ohangwena Region

*“It was really hard to see my mother suffering in her sick bed. She was sick for six months and my father suffered from the same illness. There had been a slight change since my parents died, especially my mother. I don’t have shoes anymore. Even in winter I have to go to school with bare feet.”* 14 year old double orphan - Ohangwena Region

*“My parents were very sick at the time when I was very young. I cannot really remember what happened. Everything to me is still okay, because I hardly knew my mother. To me my grandmother is my mother, and nobody can take her place.”* 7 year old double orphan from Ohangwena Region

## **Education**

Despite government’s OVC fee exemption policy, not a single caregiver interviewed said that they benefited from it. Some are able to pay school fees because of the remittances sent by surviving parents, uncles, aunts or other relatives. Others pay from government transfers they receive, such as pensions, foster care grants and maintenance grants. NGOs like NRCS, CAA and KWID have assistance programmes that help with school fees and uniforms, both of which are a great concern of caregivers and orphans.

Some household heads tried to get fee exemptions, but school administrators are reluctant to implement the national fee exemption policy. Some reported that the school offered discounts, but not complete exemptions. Others showed outstanding fee bills, and others claimed that school reports were withheld pending the settlement of outstanding school fees. When asked what the most difficult part of orphanhood was, one 17 year old double orphan from Ohangwena replied,

*“At the end of the year everybody got their school reports. I did not get mine because I did not pay my school fees.”*

Social workers argue that schools are ideal platforms to launch social interventions that can assist vulnerable children, particularly in rural areas where homesteads are far apart or difficult to reach. They also argue that children who drop out are at greater risk of abuse and exploitation and feel that government should do more to enforce its fee exemption policy. Some also felt that caregivers are often uninformed about entitlements like fee exemption. Some do not attend information meetings, and some cannot read information material which is often distributed in English.

Despite all these problems, 92 % (49 out of 53) of children interviewed were still at school. Out of the four who were out of school, one was already 21 years old, but left school in grade 9 because there was no money to pay school fees after her father’s death. One eighteen year old left school in grade 4 because of ill treatment by his own biological mother and stepfather after his father’s death. The mother used to hide his school uniform to prevent him from attending school. He has since moved to his grandparents’ home. Another 18 year old left school in grade 8 because there was no money to pay school fees. All three expressed a desire to return to school. One 13 year old never attended school because there was never any money to send him to school. At the youth-headed household only one of the six children attended school, only because a benevolent community member is paying the fees and buying the uniform. The others are simply sitting at home. Some of the household heads complained about the lack of assistance programmes for out-of-school youth. Programmes normally target those in formal education. There are no assistance programmes for those at NAMCOL or tertiary institutions.

The impressive school retention rates of this study may however mask school drop-out amongst OVCs whose caregivers are not accessing NGO assistance. Social workers, NGO workers and caregivers all expressed concern about the high number of children who have left school because of their inability to pay school fees or buy uniforms. While doing the research in the urban area of Katutura, one was struck by the number of children of school-going age who roam the streets and who beg at shopping centres and supermarkets. In the rural area one could also witness children of school-going age herding cattle. Social workers reported that OVCs are adopted in order to become cattle herders or nursemaids to younger children. This indicates a need for rigorous monitoring and evaluation of fee exemption and universal education policies.

Thirty five percent of OVCs interviewed were below the school grade for their age group. This indicates high failure rates, late school enrolment or disruptions in their education. For example in the urban area one 15 year old was in grade 3, one 13 year old in grade 2, another 13 year old in grade 3 and one 12 year old in grade 3. In the rural area one 12 year old was in grade 2, one 15 year old in grade 3 and one 17 year old in grade 9. Fifty three percent of those below age grade were double orphans, 29 percent were maternal orphans and 18 percent paternal orphans. This indicates that double orphans are more at risk with regard to disruptions in their education, and programmes should target them.

### **Psychological effects of mortality on OVCs**

This study did not specifically investigate the psychological effects and illnesses that death has on children, but in the field it became apparent that this aspect of children's well being is not being dealt with due to the tremendous struggles just to provide the material basis for subsistence.

Children have to cope with the trauma of their parents' illnesses and deaths without much discussion or counselling. Since death is often not discussed with children, they have to cope with the loss on their own. Children who did not live with their parents during the time of illness and death feel resentment, because they were only informed about their parents' deaths long after the fact. At times they did not go to the funerals or participate in the rituals associated with death and grieving in order to cope with the sense of loss.

Children who moved to different households face the sudden separation from siblings and familiar surroundings. They are simply told by the adults that they will be taken in by certain relatives. There is often no prior discussion or consultation. Social workers reported that at times children struggle to adjust to their new surroundings or to fit in with their adoptive families. Some children run away to their previous homes or become street children if their previous families are dissolved as a result of the death. Once again no street children were interviewed, so this could not be verified by the researcher.

Some of the children interviewed in this study also reported anxiety and fear of abandonment since their current caregivers are elderly grandparents who may soon die. They had concerns about who would look after them, provide food, pay school fees and provide other necessities.

### **Child Labour**

It is difficult to make the distinctions between child work and child labour since the former is deeply embedded in culture and tradition. At a cursory glance it appears that not many children are involved in child labour, but all are doing domestic chores. Seventeen percent of the children

interviewed were involved in income generating activities. They were between the ages of 12 - 21. Seven percent of household heads indicated that the children in their care were engaged in income generating activities. These income generating activities involved selling drinks in kuka shops/bars, selling wood, selling thatch grass and braiding hair. One 13 year old in the urban area admitted being involved in income generating activities, but refused to divulge what they were.

In rural areas most children are involved in agricultural activities without receiving payment. This is a longstanding tradition and is strongly embedded in the culture. These activities are normally reported under domestic chores and include cleaning the house, sweeping the yard, fetching water, collecting wood, and pounding millet, cooking, doing the laundry and cutting scrub bushes. There were a few children who, in the discussion on stigma, discrimination and abuse, reported that they felt discriminated against because they had to walk long distances to fetch water or look after the cattle. Fifteen percent of children reported involvement in more strenuous agricultural activities like ploughing, cultivation and cattle rearing. They were all males between the ages of twelve and eighteen. Most saw the work they were involved in as part of their responsibilities as family members.

### **OVCs' responses to the work they do at home**

*"I make my aunt happy by cleaning the house and cooking."* 14 year old girl from Havana (Khomas)

*"On some occasions during school holidays we look after the cattle."* 13 year old boy from Eenhana (Ohangwena)

*"I do simple things like fetching water and looking after the cattle during the cultivation season so that they do not eat the neighbour's plants, not to mention our own."* 12 year old boy from Otakondjele (Ohangwena)

*“I plough, cultivate, and fetch water and wood, pound mahangu and other things. I don’t work for money, but I will if I get the chance.”* 14 year old boy from Eenhana

*“Now that my father has died, my grandmother sends me to the cattle post to look after the cattle.”* 12 year old boy from Okongo (Ohangwena)

One crucial question is whether the work has harmful repercussions on the children, particularly their schooling. Besides those who are already out of school, all children combined their work with schooling. One 15 year old boy who works in a bar is below his school grade (grade 5). Of those involved in unpaid agricultural work, one 18 year old who left school in grade 4 is rearing cattle for his grandfather. Of the remaining six boys involved in agricultural work, two were below their school grade in relation to their age. This requires further investigation, but could indicate that their involvement in agriculture work has adverse effects on their education.

Although in this study there were no reported school drop-outs as a result of child labour, social workers and NGO workers did report youth dropping out of school and leaving their homes as a result of poverty. Key Informants in the rural area said that when they do not find work, they end up roaming the streets or begging in rural towns, but return to their homes at night. Those who migrate to the city often end up as street kids. Others drop out of school and leave the homes of their adoptive families, because they cannot cope with their new environment and the dynamics within their new families. Some simply drop out of school to hang out at shebeens because of a lack of parental supervision. Some drop out because there is no money to pay school fees or to buy uniforms.

Social workers also raised the concern that particularly boys are at risk of dropping out of school. Due to their physical strength relative to girls, they risk being adopted for the sole purpose



of cattle rearing or land cultivation. Some household heads interviewed also admitted that the children assisted them, but it was a mixture of using child labour and concern for the children's well being.

### **Household heads' responses to why they take in and keep children**

*"I kept the children here so that they can help me with the household chores."* 61 -70 year old grandmother from Eenhana

*"I will not let them go to an orphanage. They are my grandchildren and I look after them. They are helping me a lot, and they would not like to live elsewhere without me. I love them and they love me."* 61-70 year old grandmother from Ekolola

### **Sexual exploitation**

The existence of child sexual exploitation is a very sensitive question and difficult to uncover. Some social workers and NGO workers said that they have not heard of it in their operational areas, but some did report knowledge of, particularly girls, turning to prostitution in the area around Oshikango in the Ohangwena Region. This is consistent with the findings of Terry et al. One social worker reported that this often occurs with the full knowledge of caregivers because these girls become breadwinners and help support younger siblings.

One social worker argued that children who are abused at home are more likely to be exploited sexually. She reported an incident where the mother died, and the girl ran away to Oshikango where she became a prostitute, after being abused by the father's co-wife. Social workers also argue that children often vent their anger about their parents' deaths in a fatalistic way by engaging in risky sexual behaviour. Children at times argue that because their parents died of AIDS, they might as well go the same way. There are also reports of grandmothers who are unable to supervise children properly, and this leaves them open to sexual abuse and exploitation.

The social workers' claims of the sexual abuse and exploitation of OVCs are consistent with Ruiz-Casares' research findings amongst CHH in Namibia. She concluded that OVCs are often overworked and underpaid and engage in transactional sex.

### **Key Informants' and household heads' responses to sexual abuse and exploitation of children**

*"We had a case of a neighbour who kidnapped a girl and took her to Okahandja where he repeatedly raped her for two weeks. No charges were brought against him. We tried to go to the Child Protection Unit but they said that we have no evidence. We also went to the local counsellor, Meme Heleni Ilonga. There is a lot of sexual exploitation of young girls. Even their mothers at times act as their pimps."* NGO Programme Manager

*"There is some sexual molestation of female OVCs by uncles and other family members. Because of their poverty the uncles will demand sex in exchange for food, money or toiletries. Children are afraid to report the matter, but they are suffering and show signs of trauma by bed wetting. They do not wish to dress in front of other kids and isolate themselves. I have experience of children who reported the matter to aunts, who deny it or tell them not to take the matter further since they will be reporting the breadwinner, and what would happen to the family if the breadwinners were jailed?"* Namibia Red Cross Society Community Care Worker Volunteer Supervisor (Moses Garoeb Section)

*"There are children who show some anti social behaviour already when the parents are sick. They are not adequately supervised and come under peer pressure. They become involved in shoplifting, alcohol and drug abuse, and some of the girls are faced with teenage pregnancies. Sugar daddies get the girls pregnant. Mothers allow small girls to prostitute themselves due to unemployment, poverty and food insecurity. Sometimes these young girls become the breadwinners. They become involved in commercial sex work and have to look after younger siblings."* Namibia Red Cross Society Community Care Worker Volunteer Supervisor (Katutura East)

*"She just ran away for no reason. She went to Oshikango, perhaps to sell her body. I am just waiting on her to come back with a baby, a disease and die. She is so young, only thirteen years old."* 68 year old grandmother (Eenhana)

*"Lisa is my thirteen year old granddaughter who went to her father's mother after her mother died. They ill-treated her there and did not give her enough food. She was also sexually molested by a neighbour. Her clothes were torn from her. One of her father's relatives came to tell me, so I went to fetch her to stay with us."* 61-70 year old grandmother from Katutura East

### **Other risks and anti-social behaviour**

Besides sexual exploitation, social workers and NGO programme staff warned about other potential risks that could harm children's development. They reported that children frequent shebeens or kuka shops where they abuse alcohol due to a lack of parental supervision. Children are also exposed to drunkenness and violence inside adoptive families. In rural villages there is widespread alcohol abuse and there is an urgent need to protect them. Social workers were also of the opinion that some OVCs were involved in criminal activities like robbery and theft.

### **6.13 Stigma and discrimination**

The response to the question about whether HIV affected families and children orphaned by AIDS experience discrimination and stigma was mixed. Seventy percent of household heads and 60 percent of children interviewed said that they were not aware of any stigma or discrimination against them. This is consistent with Ruiz-Casares' finding that children were often unaware of different treatment by others.

NGO volunteers, however, claimed that people still hide their sick relatives in their homes because they are ashamed. As a result of this self stigmatisation, the sick relatives do not access treatment or other services available to people living with AIDS. This combined with the fact that people were at times reluctant to acknowledge the cause of deaths of relatives provides a strong indication that stigma still exists.

NRCS volunteers in Windhoek reported that people approach them for assistance for food aid, school fees, uniforms, funerals, coffins and home based care, but asked that NRCS cars do not

stop in front of their homes for the neighbours to see, for they feared the AIDS inference. In addition NRCS volunteers reported that they get stigmatised as HIV positive persons because they talk openly about the disease. Similarly a volunteer from Catholic AIDS Action reported that they prefer not to wear any identifiable clothing or insignia when they do home visits to prevent stigmatisation of their clients although they encourage people to live positively with HIV and AIDS.

Social workers and NGO project staff gave the following examples of the kinds of stigmatisation that still exist:

#### **Stigmatisation within Families**

Often affected families get isolated from extended family members who no longer visit them. Extended families may make telephonic enquiries about the sick person but avoid direct contact. One reported an example where the extended family members bought groceries and then phoned someone in the affected family to pick them up at a certain point, because they did not want to visit the house.

Some NGO workers argue that living with a sick person can be very hard on older children who feel the stigmatisation more than young children. At times the death actually frees the children from fear and stigma, because they no longer have to bear the shame and guilt of having a PLWA in their house. The shame and guilt at times causes them to withdraw from others.

One volunteer recounted a case of a daughter who left the home of the sick mother because she could no longer bear the illness and the shame it brought. She however returned to the home

to look after the younger siblings after the mother died. Some kids fear physical contact with HIV positive parents because of the lack of knowledge about HIV transmission.

Family members often feel resentment towards the HIV positive person, because they feel that they have to carry the consequences of something that could have been avoided if the person had taken the well known precautions to avoid HIV infection. At times sick persons are chased away from the family home or get isolated and neglected by relatives. One home-based care worker recalled how her patient was left to lie in his own excrement between her visitations, because the family did not want to touch him.

### **Household heads' experiences of discrimination in the family**

*“I discriminated against my son and did not want to accept him, because I warned him against sleeping around. He had children with eleven different women. In the end I took him in as well as his girlfriend and I looked after both. He asked me for forgiveness because he swore at me. People did talk, but I ignored them, for it was my child.”* Pensioner from Golgota, Katutura

*“My brother discriminated against my sister and did nothing to help her. No other people discriminated against her. When my husband died, his family discriminated against me. They said I bewitched him. His father scolded me. They stopped visiting us and have no contact with his children.”* 30-40 year old mother of six from Okahandja Park, Katutura

*“The family does not visit anymore. They did not even visit my boyfriend when he was sick, nor did they invite us for holidays or give us any assistance.”* 41-50 year old mother of two from Grysbok, Katutura

Most of the OVCs reported positive experiences inside their adoptive families, but there were those who felt stigma or discrimination inside the family. The most commonly reported forms of discrimination and ill treatment within the family were:

- Verbal abuse normally by caregivers who say, “It is not I who killed your parents.”

Children are extremely sensitive to these words, and they argue that these words get

thrown at them. There are also verbal threats that they will be chucked out of the house if they can't behave themselves.

- Unequal allocation of domestic chores like walking long distances to fetch water early in the morning.
- Physical abuse: biting
- Giving them less or inferior food compared to other children in the household.

### **OVCs' responses to whether they experienced stigma or discrimination**

*"No discrimination or ill treatment. My foster mother treats me like she treats my cousins who are her biological children."*

*"Yes, by biting me and insulting me."*

*"No, my mother and my stepfather treat me well."*

*"They treat me well and don't stigmatise me since my mother is their child."*

*"I am very happy in the house where I live although I don't have parents, but I take my grandmother like my parent because they treat me well."*

*"We are all treated in the same way, and she likes to take us all to church on a Sunday."*

*"Yes, the discrimination comes from my grandmother who uses bad words to me and tells me I can't eat."*

*"No, there is no stigma and discrimination. I am just treated the same as before my parents passed away."*

*"Yes, my grandfather tells me that if I don't behave, he will chase me away. My mother treated me badly by biting and cursing me. She also chased me away from the house."*

### **Stigma and discrimination from the community**

Children are less exposed to, or aware of, stigma than adults. Household heads complained about inquisitiveness and gossiping as the most obvious forms of stigmatisation. People may suspect that someone in the household has AIDS and therefore constantly question family members about the person's situation. Household heads are often too embarrassed to admit that their family member has AIDS, and therefore the questioning does not stop, and the topic remains uncomfortable. A few cases of verbal abuse and accusations of witchcraft were also reported.

Children experience teasing, beatings and intimidation from other children at school and in the community.

### **OVCs' responses to discrimination from the community**

*"Yes, they used to tell me that I used to wear nice clothes. Now I don't wear them anymore."* 9 year old maternal orphan from Ekolola Village, Ohangwena

*"Yes, a guy troubled us and always insulted us because our parents died of AIDS, but we told our aunt and she told him to stop."* 13 year old double orphan, Okahandja Park

The following are some of the responses from household heads in answer to the question of whether they feel discrimination from community members.

### Household heads' responses to discrimination from the community

*"Yes. My husband is the headman and they gossip continuously, but as the wife of the headman I don't take the gossiping seriously. Since we are in this position as head of the village, people will always gossip because we can't be good to everybody. We are not perfect, and even the president has enemies."* 41-50 year old woman from Otoukondjele Village, Ohangwena

*"Yes, some community members they laugh at us because we don't have anything. We are poor and they call us names. Sometimes they tease us and ask what we will eat."* 22-30 year old woman who is in a Child Headed Household in Engela

*"Yes, they are spreading rumours that I have a muti. That is why my family is dying like that. Some even shout at me that I am a witch, and that I have cursed my family in order to boost my business. It is unusual in our village that in one family people die like that. We have had continuous grieving over the past few years. This amazed people and they think that I may have done something that causes my family to perish."* 61-70 year old woman from Eenhana

*"Yes, so bad they don't like us and they don't visit us like they used to. They are saying that I am the person whose children are always dying because I lost a lot of my kids. That is the reason why they hate me. They also shout at me that the house is full of orphans, asking what we have touched that did not belong to our family that caused my kids to die as punishment."* 61-70 year old woman from Eenhana

*"Yes, since we are both HIV positive the community is inquisitive and they always ask questions."* 30-40 year old woman from Okahandja Park, Katutura

*"Yes, the neighbours are gossiping. They say we just get sick all the time and that we have the virus. They ask us why we are sick all the time because they want to hear us say that we have the virus."* 30-40 year old woman from Wanaheda, Katutura

### 6.14 Basic Needs of OVCs

Interviews with household heads and orphans were organised by an AIDS service organisation; therefore most of those interviewed came from poor families that did have the resource base to meet their own basic needs. Despite the support from NGOs and government, 90 percent of household heads said that it was not enough, and that many needs still remain unmet. The same unmet needs were repeated over and over again by both household heads and OVCs:

- Food
- Clothes



- School Fees
- Uniforms
- Blankets
- School materials like pens, pencils and books
- Medical treatment
- Transport
- Toiletries

The fieldwork was conducted during winter, and many children did not have the most basic items like jerseys, shoes or blankets to warm themselves and were constantly complaining about hunger and cold. In the urban informal settlements some complained about the lack of income to buy necessities like water or the lack of ablution facilities. They complained about the health and safety risks involved in using the filthy communal toilets where women get attacked and raped. Both in the rural and urban area children have to walk long distances to get to school.

Social workers and NGO programme officers take a much dimmer view of the deprivation. They argue that the conditions of poverty pose a risk to life itself. As a result of a decline in labour supply, some rural households are faced with conditions of famine. The lack of affordable transport also results in people dying, because they cannot access medical treatment. Although education and medical treatment are theoretically free, there are still costs involved like nominal contributions towards the school fund, school uniform, cost of transport, payments at clinics and hospitals, food for sick relatives in hospitals, and costs of accompanying relatives to hospital. These costs place the services outside the reach of some poor families. Here and there household

heads also complained about overcrowding resulting from their taking in additional people as a result of mortalities.

## **Chapter 7: Discussion, empirical generalisations and conclusions**

### **7.1 Introduction**

The research findings of this research study confirmed some of the findings reported in the international literature. However, Namibia has its own peculiarities as a result of a particular confluence of social, historical and cultural factors.

From the international literature it is clear that that AIDS related adult mortality depletes the middle layer (between children and grandparents, normally the parents). This is evident from the composition of many AIDS affected families. In the rural area the most frequently observed family form was the elderly, female-headed, matrifocal family that consists of the elderly grandmother and a number of grandchildren or even great grandchildren, who may or may not be siblings. In Namibia this tendency towards matrifocality is exacerbated by historical patterns of labour migration and the matrilineal systems of descent that require the maternal kin to take care of orphaned children. The presence of the elderly female-headed households in rural areas can also be attributed to shortened male life expectancy and even premature AIDS related male mortality.

Poverty also increases the tendency towards matrifocality, and the latest Namibian Household Income and Expenditure statistics show that households headed by elderly females are more likely to be poor. The dependency burden is increased by AIDS mortality. Remittances from the middle layer, i.e. the parents' generation who have jobs, are reduced, and expenditure to mitigate the effects of AIDS related morbidity and mortality increases.

In the urban area the majority of families in the study were also matrifocal, but with younger, female household heads. In some of these households the dependency burden on elderly, female household heads increases when children are left in the rural areas when parents migrate to the urban areas or when children are sent to the rural areas from the urban areas because parents have difficulty providing for their needs.

A greater percentage of male-headed households were found in the urban area. This could be as a result of labour migration patterns in Namibia, where in the past more men migrated to the urban area. The presence of male-headed households should, however, not lead to the conclusion that these are nuclear families. Family and household boundaries tend to be flexible in order to accommodate family members who migrate to urban areas in search of employment, sick family members living with AIDS and children who have been orphaned by AIDS, but also importantly the biological children either partner may have had with other people.

These children come on extended visits during holiday periods or come to the urban area to continue their education. There is also the exchange of cash and in-kind remittances between households, as parents pay for school fees, clothes and toiletries and other items, while rural households in the subsistence economy make food transfers to urban households. The most substantive change caused by AIDS mortality is the depletion of the middle layer i.e. the layer between grandparents and children. This has devastating consequences on households, but family boundaries should not always be equated with household boundaries. Pre-existing patterns of labour migration have already created split households, where the family is diffused across geographic space but still pools resources and shares decision making. This connects different households into extended family structures. These extended family structures provide the social

security net to most, given the inadequacies of state social security provisions. These extended family structures are also mobilised in response to AIDS mortality. The changes brought about by AIDS mortality converge with the changes, continuities and legacies of pre-AIDS socio-cultural formations.

Labour migration and the cultural practice of raising non biological children of the kinship group have given rise to the split household phenomenon, where resources are pooled and decisions about the welfare of the children are shared between members of the extended family. This situation is exacerbated by high of out-of-wedlock birth-rates. The sharing of responsibilities and pooling of resources have in some ways helped to mitigate the effects of AIDS mortality on children. Many of the children interviewed in this study did not have to move and change caregivers as a result of their parents' illnesses or deaths. They simply remained in the households where they were born and raised by grandmothers or other members of the extended family. The crucial change however was economic. With the premature death of working parents, an important source of income disappeared.

In the urban area women raise non biological children of members of their kinship group, while their children may be with others. Cases where women were raising the orphaned children of their husbands' co-wives, or the children their husbands or partners had prior to or outside the marriage/ relationship, were not uncommon.

Although this study supports the findings of the Demographic and Health Survey DHS with regard to the practice of sharing or distributing the responsibility for raising children within the kinship group or extended family, there is evidence that children do suffer abuse from

stepparents, particularly stepmothers. In some cases OVCs were returned to their maternal kin. This could be attributed to the fact that, in some Namibian cultures which trace descent matrilineally, children are not seen as the kin of their biological fathers.

The research has shown the resilience of family structures and their adaptability to the twin onslaught of AIDS and poverty. The AIDS epidemic has negative consequences on affected families. It brings about changes in family form, size, composition, demographic transition and economic circumstances. This however does not necessarily spell the end of the family. If anything, families endure despite the hardships and recompose themselves.

There is no doubt that certain family forms are under strain and dissolve as a result of AIDS mortality. The elderly, female-headed and child-headed households are examples of the changes that AIDS mortality is forcing onto family structures. However, there is little evidence to support the family decline thesis. The debate about family decline is steeped in nuclear normative assumptions of what a family is. The fact that the majority of OVCs have been absorbed into and see themselves as part of their family group indicates the resilience and permeability of extended family structures.

One should, however, not conclude that the families are coping well or that the changes are in their best interest, but rather that new or adaptive social forms emerge in response to certain structural conditions. Within family structures, diverse spatial and resource pooling arrangements arise as a result of labour migration. This does not mean an end to familial and kinship linkages that are often invoked in times of crises. At the same time new social networks and forms of

social solidarity and cohesion come into being. These social networks provide the safety net for households made vulnerable by HIV and AIDS.

In some societies the traditional, social welfare networks still operate to mitigate the impact of AIDS, and in others the disruption is so severe that they completely disintegrate. In the absence of adequate, state sponsored social security networks, vulnerable groups are left without the most basic resources to provide for their physical needs. In this study there was evidence that some households disintegrated as a result of AIDS mortality, particularly where both parents have succumbed to the disease or where widows and children have been disinherited upon the death of a father or husband.

Child-Headed Households can also emerge to offset disinheritance. Children who have lost parents may decide to remain in the house or homestead to prevent asset stripping by members of the extended family.

While the research confirms that the extended family is the primary agency responsible for orphan care, this may not always be in the child's best interest. Poverty and stigmatisation place strain on families. The strain of the additional care burden does at times cause resentment, discrimination and abuse. While colonialism and capitalist wage labour have brought about changes in family structures, the articulation of different modes of production has also resulted in the articulation of different family forms. In addition there is flexibility within cultural systems that allows for individual preferences. This variability does not always lend itself to neat categorisation or typologies. While capitalism has brought about migration, monetisation, wage labour, commodification and new class formations, it has not swept aside all pre-existing social

forms. The response to AIDS mortality reflects the plurality and hybridity of family forms in Namibia.

Sociological theory is yet to take the ethnographic constitution of African families into account. Traditional systems of lineage and descent still have an impact on inheritance systems. Shorter life expectancy associated with AIDS mortality makes matrilineal inheritance systems more severe, because death comes at an earlier phase of the family lifecycle, when women still have to provide for their dependent children. Matrilineal and patriarchal inheritance systems are central to how lineage and descent have traditionally been defined. However in the era of AIDS, it seems heartless and raises questions about whether the idealised extended family with its systems of reciprocity is in fact myth or reality. The debate, however, can only be fully understood if the sociological observer suspends certain ethnocentric judgements of lineage and descent systems and appreciates the culture and political economy of family formation in Namibia.

## **7.2 Changes in family form**

The research shows that in many pre-colonial societies different family forms co-existed. Even in groups that appeared to be culturally homogenous there were differences. Williams (1991) shows that amongst Ovambo groups within a particular area, the multi-generational, extended family with patrilineal residential patterns could exist side by side with the monogamous or polygamous or conjugal families, with neolocal residential patterns. The imposition of capitalist relations of production transformed certain family forms, as male labour migration resulted in changes in residential patterns and matrifocal, transient families, and split households became



more common, particularly in the northern subsistence economy that was a labour reservoir for the colonial capitalist economy.

Due to the combined and unequal development of capitalism in Namibia, labour became fragmented and with it the family. While men migrated (initially through brutal force) to the wage economy, women and children sustained the subsistence economy that subsidised the capitalist economy. With AIDS mortality the social reproductive and productive roles of women in the rural subsistence economy increase, as women in the rural economy take in orphans and look after the sick. Increased female migration and high out-of-wedlock birth rates place a greater care burden onto older women, particularly the maternal grandmothers within the extended family group. AIDS and poverty interface to intensify the matrifocal character of affected families.

Both male and female migration deprives the subsistence rural economy of a middle layer. HIV and AIDS intensify this phenomenon, as mortality rates amongst the economically most active, 19-49 age group, increase. Therefore the most frequently observed AIDS affected family form in the rural area is the matrifocal, extended family, consisting of grandmother and her dependent grandchildren.

In urban areas labour migration more than AIDS has brought about the biggest changes in household form. While forty-two percent of urban households in this study were male-headed and approximated the conjugal family, the majority were still female-headed, matrifocal families. Unlike rural households, these families were headed by younger females, who often had left the rural areas in search of employment.

One must exercise caution in claiming nuclearisation since family boundaries may be broader than the household boundaries. What may outwardly appear to be nuclear, conjugal or extended nuclear may at best be quasi-nuclear. Children and step children born out of other liaisons enter and exit households and move between households. The fluidity of these household boundaries is exacerbated by other members of the extended family, who migrate to the urban areas in search of employment or educational opportunities. They may take up temporary, intermittent or fairly permanent residence within the household and see themselves as part of the family rather than as non kin lodgers.

Another family form brought about or intensified by increased AIDS mortality is the consanguine family consisting of siblings and their dependent children, or that constituted as the child or youth-headed household, where adults are absent or only marginally present. The empirical evidence further shows that polygamous families still exist, and at times the care of OVCs and their offspring is taken over by the co-wives of deceased fathers.

As mortality rates interface with high levels of poverty, certain pre-existing patterns in familial groups are intensified. Firstly, the tendency of poor families towards matrifocality is intensified as female members of the family group carry the bulk of the caring burden. Traditionally there was often the separation of the biological and social reproduction functions. This explains why so many women raise non biological children from within the kinship group. The matrifocal nature of families can also be linked to how lineage and descent is traced, particularly in matrilineal societies where maternal kin are responsible for raising orphaned children. Low marital rates, high out-of-wedlock birth rates and the gendered nature of childcare have resulted in the bulk of the care burden resting on women. This may present future problems

if the feminisation of AIDS continues at its current rate, for the burden of social reproduction may increasingly transfer to elderly women and girls.

While the extended family still forms the primary social security network through remittances and transfers, the dichotomy between rural-extended and urban nuclear is a false one. The split household better captures how extended family members pool resources to mitigate the impact of AIDS. Remittance transfer flows from people listed in the OVCs support networks indicate that, although grandmothers carry the bulk of certain responsibilities for OVCs, other responsibilities are shared amongst members of the extended family, who may or may not share residential space. The dichotomy is also misleading since what may outwardly appear to be nuclear because of spatial arrangements, i.e. husband wife and children, may be a split household with fluid and transient boundaries.

The extended family is often shorthand for a number of diverse configurations of related kin. Households could consist of grandmothers and the offspring of her different children who, despite being cousins, are raised as siblings. It could also consist of grandmothers, their unmarried or unemployed children and orphaned grandchildren, the grandmother's own unmarried or married children, their children, and the children of the grandmother's maternal kin.

The migration of children between households in the kinship group also indicates that parenting functions can transfer to different members of the kinship group. This often results in blended or recomposed families where orphans are fostered or adopted into families within the kinship group. These orphans are at times separated from siblings and enter into new dyadic or triadic relationships with foster parents and their children. At times the relationships between

biological siblings dissolve as contact between the siblings becomes infrequent, or are completely severed because of the great distances between them and conditions of poverty that do not allow for visitations or travel. This indicates that while genealogical and biological connections are important, they should not be conflated with the social role of parenting since this function can be shared and transferred amongst adults within the kinship group. Historical and cultural approaches to parenting result in adults in the kinship group or community taking on caring functions for non biological children, a pattern that is intensified by labour migration and invoked to mitigate the impact of AIDS mortality.

Since only 25% of households (mostly in the urban area) indicated that they have non kin members, one could argue that in 75% of cases, family and household boundaries intersect. Even where there are non kin members such as boarders, labourers or destitute people in households, the related kin constitute the household core. They determine the household identity. Unlike collectives, communes or kibbutz, where kinship ties do not determine core identity, the reconstituted families that have blended, expanded or contracted as a result of AIDS mortality still have kinship as a fundamental criterion of identification.

### **7.3 Change in family size and composition**

The impact of AIDS mortality on family size is mixed. In certain cases it leads to a decline in family size. This is definitely the case in child and some elderly-headed households. As the data show, in a few cases the household has dissolved, resulting in stress migration. Stress migration as a result of AIDS mortality can also come about more specifically as a result of asset

stripping and disinheritance and has the twin effect of dissolution and blending. The latter therefore increase family size.

Increased family size can have both negative and positive consequences depending on the age and sex of those who migrate in response to AIDS mortality. If they are young children, it increases the dependency burden. While young children contribute towards domestic and at times agricultural labour, they cannot compensate for the loss in productive adult labour. The dependency can further increase if the migrants are sick adults, like PLWA or elderly people who cannot contribute towards domestic or agricultural labour. On the other hand, elderly people who receive state pensions contribute towards household income, as the old age pension is often an important source of income in poor, rural and urban households. If the migrants are adult women who have been disinherited, they can contribute towards OVC care and agricultural labour, if they themselves are not sick or somehow impaired. Young adolescent boys may also be adopted specifically to do more demanding agricultural work like clearing or cattle rearing, while girls are useful for child rearing, caring for the sick and doing other domestic chores.

Average household size, both in the rural and urban areas, is higher than indicated in census and household income surveys. This could mean that the impact of AIDS mortality on households was not apparent at the time these surveys were conducted. It could also mean that some AIDS affected households are bigger than non affected households, but this is concealed by aggregation. Young adults over the age of eighteen contribute towards the dependency burden. Some of the OVCs migrate to elderly-headed households and increase household size. Many of the OVCs have been living with current caregivers since birth and before the death of parents, but

the dependency burden becomes more pronounced because illness and death puts an end to the remittances parents may have transferred to caregivers.

Family size is also influenced by the family form that exists. Polygamous families, with multiple wives and their children or grandchildren, will result in bigger households than nuclear families. The consanguine, matrifocal family, with a number of female relatives and their children, will also increase household size. Consanguine families are not always matrifocal, as evidence was found of a number of brothers and sisters, their children and the orphaned children of their diseased siblings living together in a youth-headed household. In this instance age rather than gender determines power relations and household head status. In all cases the household heads were female, not necessarily because of gender, but rather because they were the oldest surviving siblings. Household size can also increase as a result of a blending of conjugal and consanguine families, where the husband and wife live together with the husband's brothers and sisters or the wife's brothers and sisters.

#### **7.4 Effects of AIDS mortality on family life cycles**

AIDS mortality, poverty and migration affect demographic transition in families. The traditional model of family life cycles in urban white and some black middle class families does not always apply. The conventional model put forward in Sociology and Psychology once again assumes middle class nuclear normativity. The model assumes that a family goes through various stages in its transition from its founding to its end. The transition starts with the single adult leaving home, getting married, raising children until they leave home, partners dying and the eventual end of that particular family. Two points are crucial to this model. Firstly, single adults

become economically independent and can leave the family to sustain families of their own. Secondly, a middle layer at a certain point takes over more responsibilities in the family.

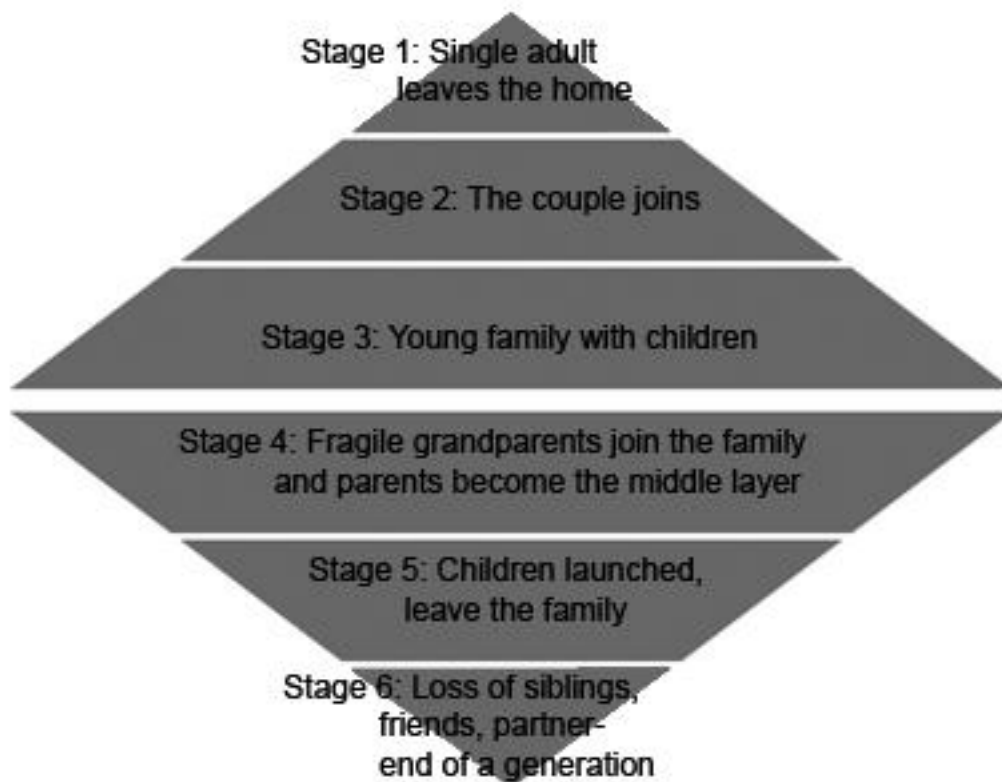
In poor families this demographic transition is delayed. Due to un- and under employment, young people find it difficult to marry and found families of their own. They therefore remain with their natal families longer. Due to matrilineal systems of descent, the young persons, particularly males, owe greater allegiance to natal families, and, as reported in this research study, in certain cultures wives and children are not regarded as family. Even when they migrate and find employment, marriage is often delayed, because they carry greater responsibility towards the upkeep of their natal families. This may account for the high rate of out-of-wedlock births. Sometimes they assist in supporting the OVCs of deceased brothers and sisters.

AIDS mortality depletes the middle layer. This leaves elderly household heads with younger children. Care and support responsibilities thus remain with the elderly or are transferred from the middle layer to the elderly upon the illness or death of the former. The care responsibilities of the elderly multiply when the family experiences multiple deaths, as AIDS often affects family clusters. Where there are no adults left to assume responsibility, child and youth-headed households emerge.

AIDS mortality further affects the family life cycle when family size increases as a result of stress migration. There may therefore be a greater number of people who enter families headed by elderly persons than those who exit as a result of death. The joint impact of AIDS and labour migration results in the constant replacement of those who have died by those who have been orphaned or whose parents left them in the care of elderly grandparents. Household and family

composition may therefore be reconstituted constantly, as children and sick people join the household, while some others migrate or die. This may explain why there are not always decreases in household size as the families go through different life cycle phases.

**Graph 26: Middle Class Nuclear Normative Family Lifecycle**

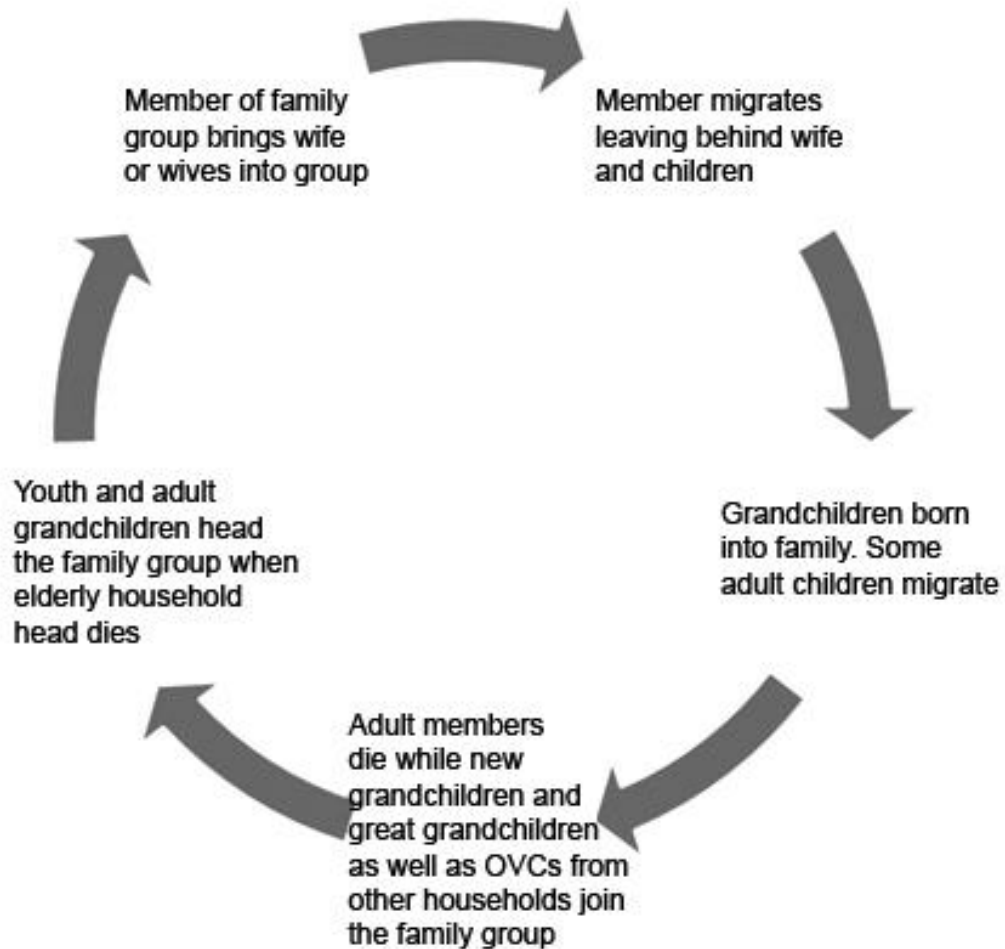


Graph 26 above illustrates the traditional family lifecycle model that assumes a certain demographic transition between generations. The model is based on the assumptions of a middle class, nuclear family with neolocal residence. However, as Graph 27 below shows, poor, rural, AIDS affected families have more flexible boundaries, and there are constant entries and exits as a result of marriage,



migration and mortality. There is thus a cycle that leads to the survival of the family group despite the diminishing middle layer.

**Graph 27: AIDS affected rural extended family lifecycle**



## 7.5 OVC Care

Despite the strain of an additional care burden, the majority of household heads who had taken in OVCs indicated that they were from the kinship group and rejected notions of fostering outside the kinship group. In addition to emotional attachments, caregivers feel culturally obliged

and fear ostracism from others in the kinship group or in the community. This reinforces the point that kinship is an important form of identification and a socio-culturally constructed basis for group solidarity.

The widespread rejection of institutionalisation by household heads caring for orphans is based on the fear that children will be abused or ill treated by non kin. This fear may not be unfounded, as reports cited in the literature confirm that children in institutional care often suffer neglect. There is, however, a fine line between established cultural norms and the state's abrogation of its responsibilities towards weak and vulnerable members of society. There is a tendency for the neoliberal state to absolve itself from social service provision. The state then hides behind decentralisation and social capital discourses to mask this abrogation. These policy discourses are supposed to reflect the democratic nature of a state when it transfers its responsibilities for OVC care to women and poor households. There are children who cannot be absorbed into extended family structures, or who suffer neglect and abuse inside the extended family. In addition there are insufficient systems to monitor the wellbeing of OVCs inside adopted families and in institutional care.

## **7.6 Conditions OVCs find themselves in**

It is difficult to discern whether children who have been orphaned or left vulnerable are in the condition as a result of AIDS related adult mortality, or if there are other causes, because the cause of death is often not known to the children or not acknowledged by relatives. However, given statistical data on the most common causes of death in Namibia, it is safe to say that AIDS mortality is the primary cause of orphanhood and vulnerability. OVCs are already faced with

multiple exclusions, and the impact of their deprivation is still unfolding. While the majority of the children interviewed in this study felt loved and accepted within the families that adopted them, they face conditions of poverty, and often their most basic needs for food, clothing, shelter, security and education are not met. Besides the material deprivation, very little attention is given to the psychological trauma caused by death. They seldom receive counselling, and in certain cultures it is taboo to discuss death with children. There is a need for greater openness and the space that will allow children to grieve their losses.

Children raised by elderly grandparents are often not adequately supervised. Some engage in risky and anti-social behaviour, and a minority face exploitation and abuse. All this seems to indicate the need for ancillary, community-based structures like day-care centres, after-care centres, counselling centres, holiday camps and school feeding schemes that can support the extended family with its care burden. Legal and policy instruments are not always enforced to uphold the rights of children, be it extended family or institutional care situations.

## **7.7 Economic and Social Reproduction**

The literature shows that families are more likely to be dissolved when women succumb to the disease, because of their role as primary caregivers and social reproductive roles. This study shows that AIDS related mortality increases the poverty of affected families due to income loss, loss of labour, sale of future income producing assets such as cattle, and increased expenditure due to illness and death. In addition AIDS increases the dependency burden because fewer adults have to care for more children and sick people.

The dire circumstances of many families are reflected in stress migration, food insecurity, declines in food and agricultural production, and lack of money for school fees, books, uniforms and other necessities. Social transfers like pensions, maintenance and child support grants are not sufficient to overcome conditions of poverty. It is also uncertain how long extended families can continue to play their role in the care economy, as the HIV infection rate is still rising, and this could mean high mortality rates for a considerable time.

The fact that child-headed households are not widespread in Namibia does not mean that this is not likely to change in the future. There is dispute about whether coping is a misnomer since people are struggling to survive. The empirical findings show that AIDS affected families often face conditions of famine. This can hardly be termed coping, and as many OVCs and household heads put it, they are suffering.

While AIDS mortality intensifies a pre-existing child care pattern of grandparents raising the offspring of their migrating children, there is one important difference. Remittance transfers by the middle layer diminish as a result of premature death. Government support grants are inadequate replacements. A cycle of susceptibility and vulnerability is created when children and women in families that have experienced AIDS mortality engage in risky sexual behaviour as part of their survival strategy. It is thus not accidental that many families in this study experienced multiple AIDS deaths.

AIDS affected families have better life chances when one or more members can retain formal sector jobs. The majority of those interviewed in this study were either engaged in subsistence farming, unemployed or engaged in informal sector survivalist enterprises. This

supports the findings of previous studies that poor families are more susceptible and vulnerable to HIV and AIDS and less able to mitigate its impact. The cause and effect relationship between HIV/AIDS and poverty produces a mutually reinforcing cycle. As poverty is transferred from one generation to the next, it reproduces susceptibility and vulnerability. The evidence also shows that AIDS mortality produces more poverty, discrimination, new forms of social stratification and social exclusion. It also reproduces social and economic inequalities, as already impoverished, female headed households have to take on the additional care burden. In addition children raised under conditions of poverty will most likely suffer other forms of exclusion and marginalisation, such as exclusion from education opportunities, adequate nutrition and healthcare, and remain socially disadvantaged for the rest of their lives. The social costs of orphanhood have not been measured. Children who are socially excluded and inadequately supervised may turn to risky and anti-social behaviour. The cycle of poverty and exclusion may therefore continue and bring about future generations of impoverished and socially excluded people, and susceptibility, and new waves of HIV infection.

Despite legislation to protect widows and children, customary inheritance patterns are still resulting in the expropriation of property by the deceased husband's relatives. This increases the poverty of women and children. Women are then forced to migrate in order to find new sources of livelihood. They may return to their maternal kin, migrate to urban areas, or band together with other women to raise their children in reconstituted households. In some cases households dissolve, and the property is divided amongst the deceased husband's kin. Where the children of the deceased are old enough, they may remain to guard the property and form child-headed households. They may lack the knowledge and skills needed to keep up the same levels of output as the parents did prior to illness and death.

The literature indicates that one strategy to compensate labour losses caused by adult mortality is to adopt orphans, but this is difficult to prove. Most people interviewed who took in orphans would not admit to this being a primary motive for doing so. Some did, however, admit that some children were assisting them with agriculture and domestic chores, and a few children were also involved in income generating activities. Social workers confirm that orphans are adopted to become cattle herders, domestic workers and nursemaids in adoptive families even when they are related kin. Under these circumstances it is questionable if the best interest of the child is served as required by the Namibian Government's OVC policy. The extended family can at times be a rather illusive entity. The romanticised version is that of a multi-generational family that exists in a state of mutual support and harmonious cooperation. In the absence of adequate, state-funded social security systems, the extended family does provide support to the majority of Namibians, particularly in times of crises. Those who have benefited from this support, or who may require it in the future, are expected to reciprocate the support to others in the kinship group or to the children of those who have assisted them in the past. The systems of familial obligations and reciprocation could go back many generations to include social debt incurred by previous generations. Systems of reciprocation, remittances, transfers and shared child care arrangements within the family group are often imposed by culture and can invoke feelings of resentment from those who are called upon to pool resources.

## **7.8 Stigma and discrimination**

Despite the Namibian Constitution and legislation, family members still strip others, often more vulnerable members, from assets. Asset stripping is often accompanied by intimidation,

threats, accusations of witchcraft and even physical violence. In this study members of the extended family conceded to discrimination and stigma towards HIV/ AIDS affected families within the family group. In addition the abuse of child support grants and the adoption of children in order to access such grants all show a dark side of interfamilial relations, and this behaviour calls into question romantic notions of the extended family.

Self stigmatisation and stigma by health care workers and members of the community can also lead to isolation and a refusal to access HIV and AIDS related services like VTC and ARV treatment. Although there is increased openness, there is also a need for further interventions that can address the different forms of stigmatisation.

## **7.9 Role of the State**

This far the Namibian Government has been active in policy formulation, education and prevention programmes, VTC, condom distribution, the provision of treatment, social grants, counselling services, emergency food assistance, school feeding schemes and school fees exemptions, and health service charge exemptions. These efforts must be applauded. Despite all these efforts, HIV infection rates are still rising, and many AIDS affected families still remain destitute. It could, however, also confirm a supposition introduced in Chapter 3 that poor people are more susceptible to HIV infection, more likely to experience mortality and less able to mitigate the impact of that mortality.

This calls into question the efficacy and effectiveness of government policies and programmes. Some programmes fail to take the views of affected persons into account, and some are simply not well targeted. In some cases it is simply too little too late.

Besides the fact that current budgetary allocations are insufficient, the institutional infrastructure is not geared towards effective service delivery. There are problems with the nature of the grants, mainly because they do not cover all aspects of AIDS vulnerability or address the destitution of PLWA. They are also too small to offset food insecurity in households where people have lost income or labour as a result of death. Food insecurity in turn threatens the effectiveness of ARV treatment programmes. It also exposes children to risks and vulnerabilities, as some are forced into the role of providers by engaging in income generating activities. Some of these activities are exploitative and have a negative impact on them, i.e. their ability to stay in school, performance at school, the risk of HIV infection due to sexual exploitation, unwanted pregnancies and participation in criminal activities.

Accessing grants is not always easy. Lack of national documents required to lodge applications is a big impediment, and government will have to seek alternative means of verification since in some instances births were not registered. The slow rate at which the bureaucracy is able to process national documents and lack of personnel to screen grant applications cause delays and long waiting periods between application and the actual receipt of social transfers. There is no effective monitoring and evaluation system to ensure that support services reach the intended beneficiaries or to eliminate wastage and abuse in the social grant system.



Besides the immediate administrative impediments to service delivery, there are some fundamental political issues that underlie policy formulation and implementation. First, most of Namibia's HIV/AIDS programme funds come from donors, and donors set the parameters of policy discourse through their consultants who advise governments, international policy guidelines and actual disbursements of programme funds.

Secondly, Namibia has a plethora of policy documents. Some have never been fully or successfully implemented, because they lack the budgetary support and administrative capacity needed for successful implementation. Many of the policies are HIV and AIDS specific, such as the HIV/AIDS policy, OVC policy and the HIV/AIDS Code of Conduct. Others are related to the problems of inequality, such as Vision 20/30, the National Gender Policy and the Poverty Reduction Strategy.

There have been calls (particularly from donors) to mainstream both HIV/AIDS and Gender. This means that every aspect of public policy should reflect consideration of gender differentials or HIV/AIDS susceptibility and vulnerability. However there is already an overwhelming proliferation of policy documents and declarations of intent to satisfy donor requirements with related blueprints for implementation and reporting. This has created the complex maze of documents, conditionalities and reporting requirements that divert skills from actual programme implementation. Often the main object of policy is geared towards meeting reporting requirements.

With mainstreaming, policy makers are advised to suspend area specific budgeting and to incorporate these aspects into the overall budgets to avoid the ghettoisation of gender or

HIV/AIDS. This, together with neoliberal contractionary fiscal policies (the fiscal squeeze), results in the under-funding of HIV/AIDS and gender from own sources. Instead of mainstreaming, there is a need for the streamlining of gender and AIDS policies and programmes. Multiple and contradictory policies should be harmonised and made implementable given local capacities and resources. Policy streamlining and harmonisation should translate into a limited number of easily recognisable and traceable targets for a specific period of time with specifically dedicated budgets.

These expert models of policy making are not politically neutral or free from power relationships. Local social workers, members of civil society and PLWA have been calling for the local sourcing of food aid for nutritional support programmes run by WFP. This can contribute towards the local economy and help with poverty alleviation, yet there is an insistence on imported maize that has lower nutritional value and is less diverse than locally produced millet beans, nuts and spinach. These are traditional crops that are grown in Namibia's subsistence farming sector. Sourcing from these farmers could provide the incentive to increase food production and provide jobs to the unemployed PLWA. The call by locals to source locally has so far gone unheeded.

Most of the discussion on HIV and AIDS occurs in the bio-medical or behaviouralist realms. There is very little discussion on the structural causation side of HIV and AIDS. There is need for a national discussion on the structural conditions within which policies are formulated and implemented so that the possibilities of achieving the desired policy outcomes are assessed. At times the policies cannot reach the desired outcome because of structural and systemic factors. To address structural level inequalities, one would have to challenge some "holy cows" such as patriarchy, capitalism and male sexuality. Whether or not the levels of poverty and inequality can

be resolved within free market capitalism is debatable, but to even suggest an alternative is often regarded as seditious, and so the same unworkable policies are recycled and repackaged (sometimes under different names) but with the same lack of efficacy. Discussions on alternatives remain muted and are quickly silenced.

The recognition of causal relationships between HIV/AIDS, gender, “race” and class should result in redistributive policies and programmes, yet initiatives to this effect are stifled by policy advisors and the Namibian Government. The Basic Income Grant was for example, rejected by both the IMF and the Namibian Government. Policy proposals from “progressive NGOs” such as Oxfam still hover in white, Western, middle class norms when they call for redistributive measures that benefit socially excluded minorities, i.e. women, Blacks and poor people. In Namibia these last three groups make up the majority.

While focus is on the bio-medical, there is an absence of debate on the political economy of HIV/AIDS. The result is a perpetuation of band-aid policies that can neither stop the spread of the disease nor protect large constituencies of poor people from vulnerability. It is therefore no accident that the same people who are most susceptible to HIV infections are left to battle with its impact and the least able to mitigate it.

Despite feminist calls for the remuneration of women’s social and biological reproductive work, the care burden has increased, with female caregivers having fewer resources to deal with the increased burden. There is little recognition that women in the care economy should be remunerated.

## 7.10 Policy Recommendations

### Household level interventions

Since families carry the burden of impact mitigation, Harvey makes the following policy recommendations that can help households and families affected by AIDS.

**Table 21: Harvey model for household coping and strengthening strategies** (Harvey 2003: 36-27)

Sources of capital	Impact of HIV/AIDS	Coping/Survival Strategy	Policy Interventions
<b>Human</b>	<ul style="list-style-type: none"> <li>-Reduced labour availability</li> <li>-Reduced output</li> <li>-Reduced time for other income generating activities</li> <li>-Little knowledge -transfer</li> <li>-Loss of knowledge and skills</li> </ul>	<ul style="list-style-type: none"> <li>-Shift to less labour intensive crops.</li> <li>-Reductions in the range of crops</li> <li>-Decrease in land under cultivation</li> <li>-Use of labour saving technologies and hired labour.</li> <li>-Use of child labour</li> <li>-Recomposition of households</li> <li>-Withdrawal from certain income generating activities</li> </ul>	<ul style="list-style-type: none"> <li>-Research into low input, low labour crops</li> <li>-Adapting agricultural extension programmes</li> <li>-Training and support for livelihood diversification programmes.</li> <li>-Promotion of labour saving technologies</li> <li>-Marketing support</li> <li>-Provision of basic health including ARVs</li> <li>-Support with agricultural inputs like seeds, tools and cropping systems</li> <li>-Labour intensive public works for the chronically ill</li> <li>-School feeding schemes</li> <li>-Waiver of school fees</li> <li>-Home-based care and orphan care support programmes</li> <li>-Distribution of food aid and nutritional supplements</li> <li>-Innovation educational alternatives for school dropouts</li> </ul>
<b>Financial</b>	<ul style="list-style-type: none"> <li>-Loss in income</li> <li>-Loss in remittances</li> <li>-Loss of access to credit</li> <li>-Reductions in assets</li> <li>-Increased health expenditure</li> <li>-Increased expenditure on funerals</li> <li>-Increased number of orphans to care for</li> </ul>	<ul style="list-style-type: none"> <li>-Decreased consumption</li> <li>-Consumption of inputs like seeds</li> <li>-Sale of assets like land and cattle Increased debts</li> <li>-Risky survival strategies like transactional sex</li> <li>-Begging</li> <li>-Participation in informal savings clubs</li> <li>-Rental of land</li> </ul>	<ul style="list-style-type: none"> <li>-Reduced tax burden</li> <li>-Reduced corruption and theft in resource allocations</li> <li>-Cash grants for affected households</li> <li>-Agricultural input grants or subsidies</li> <li>-Livestock interventions like restocking</li> <li>-Support for income generating activities</li> <li>-Support for micro-finance institutions</li> </ul>

<b>Social</b>	-Community Based organisations like churches are weakened -Increased possibilities of default to formal and informal credit institutions -Institutional stigmatisation of HIV positive persons -Overburdened traditional customs of remittances  -Land tenure systems not able to address the needs of widows and orphans -Reversal of urban rural support networks	-Emergence of new institutions to address HIV/AIDS -Adaptation of existing institutions -Changing customs like funeral practices -Orphan care left to the elderly and -Emergence of Child Headed Households	-Support for civil society institutions -Promotion of changes in land tenure patterns and institutions -Transformation of gender roles
<b>Natural</b>	-Widows and orphans lose land-use rights -Land not maintained -Lack of environmental protection leads to loss of productivity	-Sale / rental of land -Changes in cropping patterns -Remarriage and early marriages for women and girls in order to gain or retain land-use -Leviratic marriage to retain land-use -Forced celibacy to retain land-use	-Changes in gendered land tenure patterns Relaxation to enable sub-letting without the loss of tenure
<b>Physical</b>	-Sale of productive assets like land and livestock -Productive assets like irrigation and storage systems not adequately maintained -Household assets like houses and fencing not maintained	-Distress sales of key productive assets -Community-based organisations carry out house repairs for affected families	-Provision of non-food items Water and sanitation intervention

In this study informants also came up with multiple suggestions to improve the situation of OVCs. These are:

### **Policy Recommendations**

#### **a) Household Heads' Policy Recommendations:**

##### **Rural Areas**

- The government should increase grants to cover the needs of the orphans, pay school fees and uniforms and to buy medicine in the pharmacies.

- The government should provide affected families mahangu and cattle.
- The government should provide OVCs free education, counselling services and sex education.

### **Urban Areas**

- OVCs need assistance with education, food and school uniforms to prevent them from becoming street children.
- Income generating projects should be initiated.
- Social grant applications should be processed with greater speed.
- OVCs should get food, clothes, especially uniforms and blankets during winter.
- All orphans should get social grants.
- Government should provide financial assistance for those who wish to enrol at NAMCOL.
- There is a need for bursaries for OVCs who wish to attend tertiary institutions.
- All OVCs should be exempted from school fee payment.
- Provide counselling services to OVCs.
- Unemployed HIV positive persons should get a grant.
- Job creation for HIV positive people who are still healthy.

### **Policy Recommendations by Social Workers and NGO workers and Volunteers**

- There is a need for proper research and statistical data upon which policy interventions are planned.
- Government should set up a national OVC data base, and ensure that children are registered on the data base. There is a lot of duplication. Some claim grants and benefits from different organisations while there are others who do not benefit at all.

- The issuance of national documents should be facilitated through mobile units that visit rural areas to process birth and death registrations and applications for identity documents.
- The processing of social grant applications should be expedited by appointing more social workers and judicial officers who do the screening and vetting of such applications.
- Affidavits of community, religious and traditional leaders should be accepted to verify the status of applicants in the absence of national documents.
- A more effective system should be developed for monitoring and evaluating policy implementation and services rendered by government and non governmental institutions to ensure that the best interests and the rights of children are protected.
- Community and traditional leaders or volunteers should be used to assist with the monitoring and evaluation of services and to report any abuse of OVCs as well as the abuse or misuse of social transfers.
- There should be a greater focus on psychological and material needs of OVCs.
- There is a need for education and community mobilisation to uphold children's rights.
- Government and international aid agencies should source food aid locally for it is cheaper, varied and can benefit the local economy.
- The amount and outreach of social grants should be increased.
- Social grants for people PLWA should be provided.
- Government should introduce the Basic Income Grant.
- There should be enforcement of the education for all and fee exemption policy.
- There should be public hearings and grass roots consultations in the process of policy formulation, implementation and evaluation, including consulting children/youth on policies that could benefit them.

- Road markings should be improved because social workers in rural areas often waste a lot of time because they get lost or can't locate clients.
- A moratorium should be placed on the eviction of HIV/AIDS affected families by municipalities for the non-payment of service charges. Municipalities should either freeze or write off debts and transfer property into the name of the children to avoid asset stripping by greedy relatives, lawyers or others in the community.
- Jobs should be created for OVCs over the age of eighteen and for PLWA.
- Income generating projects for PLWA should be created.
- The most important ways of ensuring that OVCs stay in school are the early recognition of vulnerability, timely response, a good referral system that can help children access available resources as well as a system that can monitor their wellbeing.
- Hostel accommodation for school going OVCs should be increased to alleviate the burden on grandparents.
- The provision of institutional care needs to improve to accommodate children not absorbed into the extended family or those who are abused or neglected inside the extended family.



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## Annex 1: Household Head Interview Schedule 1

**NO.** -----

### Household Heads Administration Block

Name of interviewer	
Name of note taker	
Others	
1. Location	Town/Village-----2. Region-----
Date:	Starting time-----Finishing time----- Total time-----
Interviewer Self-check	

### Introduction

Greetings:

My name is -----, I am with a lecturer from the University of Namibia. We are currently conducting research on how HIV/AIDS affects families in this region. We have identified you as one person who could enlighten us on the subject and would like to request that you share your knowledge and experiences with us. We know that some of the information we are asking may be painful to share. Although we would like to know as much as possible, you have the right to decide what information you wish to share with us. We ensure you that we will observe anonymity, confidentiality and privacy. We will therefore not reveal your name or what you have told us to any other persons.

### Demographic Details of Informants:

**Code**

3. Year born/age: -----> 18 ----- 19- 21 -----22-30 -----30- 40 -----41-50 ----- 51-60 ----- 61-70 -----71-80 -----<80	
4. Sex: ----- Male -----Female	
5. Occupation:	
6. Marital Status: ----- Married ----- Separated -----Divorced -----Widowed-----Co-habiting ----- Single -----Other	
7. Home language:	

### 8. Household Type

	Female Headed
	Male Headed
	Elderly Female Headed (over 60)
	Elderly Male Headed (over 60)
	Child Headed (below 18)
	Other. Specify

**Composition**

9. Number of persons living in the household permanently (more than 9 months per/year) -----

10. Number of adults living in the household permanently (over 18 yrs):------  
 No. Males ----- No. Females -----

11. Do you have any non-relatives living in your household?

----- Yes ----- No

12. If yes to Q11. What number of Non- relatives?-----

Number of Non Relative Adults ----- No of Non relative Children -----

13. Any children who live in the household permanently (under 18 yrs)?:-----  
 ----- Yes ----- No

*If yes to Q12 go to Q 13. If no to Q 12 skip to Q20.*

14. No. Males----- No.Females -----

*If no children skip to question NO.19 if there are children go to question No.13*

15. *If any children.* How many children in the household are your own biological children? -----  
 -----

16. *If any children.* How many children in the household are **not** your own biological children? -----  
 -----

17. *If any non biological children in household.* What is the HH's relationship to the non biological children in household?

	Grandparent: -----	Daughter's child -----	Son's child -----
	Uncle :	Sister's child -----	Brother's child -----
	Aunt :	Sister's child -----	Brother's child -----
	Sibling:	sister -----	brother -----
	Sister's or brother's grandchild		
	Cousin's child		
	Friend's child		
	Neighbour's child		
	Other- Specify		

18. Why did you take in non biological child/ren?

-----  
 -----  
 -----

19. Do you regard the non-biological children as part of your family?

----- Yes ----- No

20. If yes or no to Q 18. Give reasons for your answer.

-----  
 -----  
 -----

Are there any orphans in the household?

-----Yes ----- No





33. *If yes to 31.* No. Of Adults ----- No. Children -----

34. *If yes to 31.* What were the reasons for them coming to live with you?

-----  
-----  
-----  
-----  
-----

35. Have any other people left the household in the last 3 years?

-----Yes -----No

*(If yes to Q35 go to 34 if no to Q 35 skip to Q 39)*

36. . How many people have left the household in the last three years? -----

37. *If yes to 35.* N0: of Adults ----- N0: Children -----

No: of Female Adults ----- No: Female Children -----

No: of Male Adults ----- No: Male Children-----

38. *If yes to 35.* Why did they leave the household?

-----  
-----  
-----  
-----

39. Do you have non permanent people in the household? *(live in household for less than 3 months p/y)*

----- Yes ----- No

40. *If yes to Q 39.* How many non permanent members in household? -----

41. No: Female----- No: Male-----

42. Number of non permanent adult members of household -----

43. Number of non permanent children members of household-----

44. *If any non permanent members in household.* Where do they live at other times of the year? (place) -----

-----  
-----  
-----  
-----

46. Do you regard these non permanent household members as part of your family?

----- Yes -----No

47. Have you had any deaths in the household over the last three years?

----- Yes -----No

48. What was the relationship between HH and the deceased? (*tick correct block*)

h	nt	her	r	dchild	dparent	sin	Other. specify
---	----	-----	---	--------	---------	-----	----------------

49. What was the cause of death? -----  
-----  
-----

**Impacts**

50. Did the death of the deceased result in any changes in the household?

----- Yes. -----No.

51. *If yes to 50.* Please explain how it changed your family.

-----  
-----  
-----  
-----  
-----

52. Do you currently have any sick person in the household?

----- Yes -----No (if no skip to? Insert number)

*If yes to Q52 go to Q 53. If no to Q 52 skip to 60.*

53. What is the relationship of HH to sick person?

(*Tick correct block*)

ch	par	brot	sis	grandchi	grandpare	cou	Other -specify
----	-----	------	-----	----------	-----------	-----	----------------

54. *If yes to 52.* Did the sick person live elsewhere before he/she became ill?

-----Yes ----- No

55. *If yes to 52.* Where did the person live before?

-----  
-----

56. *If yes to Q52.* Who takes care of the sick person on a daily basis?

-----  
-----

57. *If yes to Q52.* Were there any changes in the household as a result the illness?

----- Yes ----- No

58. *If yes to 52.* What changes occurred in the household as a result of the illness? (*Please write neatly*)

-----  
-----  
-----  
-----  
-----

59. *If yes to 52.* Why did you take the sick person into your home?

-----  
-----



(Tick correct block)

ch	par	brot	sis	grandchi	grandpare	cou	Other- specify
----	-----	------	-----	----------	-----------	-----	----------------

69. What are the in-kind contributions?

-----

-----

-----

70. Do you receive any other assistance from any of the following organisations? (Tick below)

Relatives	NGOs	Churches	Community Members	Friends	Other

71. What kind of assistance do you receive?

	Money	From whom
	Payment of school fees/uniforms/books and materials	
	Medication	
	Food	
	Clothes	
	Blankets	
	Counselling	
	Help with looking after children	
	Help with caring for the sick	
	Other- specify	

72. Are these contributions sufficient to cover your needs?

----- Yes

----- No

**Household Expenditure**

73. What is your monthly expenditure on the following?

Amount in N\$	Items
	Education: school fees/uniforms/books and materials
	Medication
	Food
	Clothes
	Blankets
	Fuel /energy/electricity
	Water
	Transfers to others – if so who?
	Other. Specify

74. Did any of your expenditure increase as a result of illness of a household member?

----- Yes ----- No *If yes. By what amount?* -----

75. Have you incurred any additional expenditure as a result of the death of a household member?

----- Yes ----- No *if yes what kind of expenditure?*

-----

-----

-----

76. Do you make any in-kind contributions to other people not living in house (e.g. Food) if so to whom?

-----  
 -----  
 -----

**Inheritance**

77. Did any of the orphans living in your house receive any inheritance as a result of the death of a parent/parents?

----- Yes ----- No

78. If yes to Q 77. What did they inherit?

Type of property	Inherited from Mother	Inherited from Mother
Land		
Cattle		
Other lives stock		
Agricultural implements		
Clothes		
Crafts/Jewellery		
Millet/grain		
Furniture		
House		
Household items		
Other, specify below		

-----  
 -----

79. If no to Q 77. Who inherited the deceased parent's property?

-----  
 -----  
 -----

**Stigma and Discrimination**

80. Do you feel that people treat you or the children in your household any differently to others in the community?

----- Yes ----- No

81. If yes to Q80... How do they treat you or the children differently?

-----  
 -----  
 -----  
 -----

82. If yes to Q81. What do you think are the reasons why they treat you differently?

-----  
 -----

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-----  
-----

83. If your household has been affected by AIDS illness or death, what are the biggest challenges/ problems you are currently facing?

-----  
-----  
-----  
-----  
-----

**OVC Care Arrangements**

84. If you are taking care of orphans, would you consider sending them to non-relatives to be cared for?

----- Yes ----- No

85. *If no to Q84.* Why would you not send them to non relatives?

-----  
-----  
-----  
-----

86. *If yes to Q84.* Under which circumstances would you send them to non relatives?

-----  
-----  
-----  
-----

87. Would you send the orphans to an orphanage?

----- Yes ----- No

88. *If no to Q87.* Why would you not send them to an orphanage?

-----  
-----  
-----

89. *If yes to Q88.* Under which circumstances would you send them to an orphanage?

-----  
-----  
-----

90. If you are taking care of OVCs, who makes the decisions about their:

Education	Household	Surviving parent	Other relatives	Child
Medical Treatment				
If they should work				
Who they could marry				
Their upbringing				
Discipline				

91. What do you think could be done to improve the situation of OVCs and the families that care for them?

**92. How can families affected by HIV and AIDS be best supported and who should support them?**

**General Comments**

**Thank you for your time**



## Annex 2: Interview Schedule: Key Informant Interviews (KII)

**Professionals: Social Workers, NGO Workers, Community Leaders, Nurses, Teachers**

NO. -----

### Administration Block

Name of interviewer	
Name of note taker	
Others	
1. Location	Town/Village-----2. Region-----
Date:	Starting time-----Finishing time----- Total time-----
Interviewer Self-check	

### Introduction

Greetings:

My name is -----, I am with a lecturer from the University of Namibia. We are currently conducting research on how HIV/AIDS affects families in this region. We have identified you as one person who could enlighten us on the subject and would like to request that you share your knowledge and experiences with us. We know that some of the information we are asking may be painful to share. Although we would like to know as much as possible you have the right to decide what information you wish share with us. We ensure you that we will observe anonymity, confidentiality and privacy. We will therefore not reveal your name or what you have told us to any other persons.

### Demographic Details of Informants:

3. Sex:

4. Occupation:

5. Organisation working for:

No. yrs:

6. Do you distinguish between AIDS orphans and other OVCs? If so why/not?

7. Services your organisation provides to HIV affected families:

8. Specific work with families affected by HIV/AIDS:

9. How are families that experienced illness affected by it? (*Economically, emotionally, size, composition, functions, responsibilities, stigma*)

10. How are families that experienced death affected by it? (*Economically, emotionally, size, composition, functions, responsibilities, stigma*)

11. How are children affected by illness or death of a parent?

a) Emotionally

b) Materially: Resources

c) Risk of physical, sexual, emotional abuse:

- d) Risk of economic exploitation
- e) Educationally
- f) Risk of anti-social behaviour:
- g) Stigmatisation and Discrimination
- h) Health
- i) Inheritance and property

11. What are the most glaring differences between HIV affected and non affected families?

12. What are the biggest needs of HIV/AIDS affected households?

13. Who carries most of the burden of Orphan care?

14. What role does the extended family play in supporting OVCs? (*Economically, emotionally, size, composition, functions, responsibilities, stigma*)

15. What do you propose decision makers could do to improve the situation for HIV/AIDS affected Families?

16. What do you propose decision makers could do to improve the situation for HIV/AIDS OVCS?

17. General Comments

### Annex 3: Household Interview Schedule 2

Additional Questions: Household Heads

Biographical Details

Place: ----- Sex: ----- Age: -----

Occupation: -----

1. How many children are you looking after who are not your own biological children?

----- (number)

2. Whose children are they? (e.g.

Sister's children -----

Son's children -----

Brother's children-----

Brother's son's children-----

Cousin's children-----

Grandchildren of my brother-----

Other: Please specify-----

Sister's daughter's children -----

Daughter's children -----

Brother's daughter's children -----

Children of my grandchild -----

Children of my sister -----

3. How did the children come to your house? (*explain the circumstances and reasons*)

4. What happened to the children's parents?

5. What happened to the homes that the children were living in before they came to you?

(*Find out if the homestead was abandoned , if the home was taken over by other people, if the family split up and if the children were divided up and given to different caregivers.*)

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-----

6. Did you also take in adults? \_\_\_\_\_

-----7. *If yes to 6.*  
How many adults did you take in? ----- (number)

8. *If yes to 6.* Who were these adults? *(What is the relationship to the household head?)*

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-----  
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9. *If yes to 6.* What were the reasons for taking them in? -----

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-----

10. Are there any children in your family group who have not found a home and are roaming the streets or left without adult care? (If yes, find out the reasons why they are on the street.)

-----  
-----

Thank you for your time and for the information.

**Annex 4:**

**University of Namibia: Ph D Research N0. -----  
Interview Schedule: Children’s Focus Group Discussion**

**Administration Block**

Name of interviewer	
Name of note taker	
Others	
Location	Town/Village-----2. Region-----
Date:	Starting time-----Finishing time----- Total time-----
Interviewer Self-check	

**Introduction**

Greetings:

My name is ----- . I am with a lecturer from the University of Namibia. We are currently conducting research on how HIV/AIDS affects families in this region. We have identified you as one person who could enlighten us on the subject and would like to request that you share your knowledge and experiences with us. We know that some of the information we are asking may be painful to share. Although we would like to know as much as possible you have the right to decide what information you wish share with us. We ensure you that we will observe anonymity, confidentiality and privacy. We will therefore not reveal your name or what you have told us to any other persons.

**3.**

Case no	Sex: M/F	Age	Grade	Time orphaned	Maternal/ Paternal/ Double	Other Siblings	Caregiver: GM/F/U/A/S/B OR/ N / F/ ONR

**Care Giver Code:** GM= grandmother; GF= grandfather; U= uncle; A=aunt; S= sister; B= brother, OR= other relative; N= neighbour; F= friends; ONR= non relatives

**4. Education:** *If the participant has already left school*

Case No	Last grade completed	Reason for leaving school	Intention to return to school: Yes/No

Effects of parent’s illness or death on child

5. How did your parent’s death change your life?

- 1. -----  
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- 2. -----  
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- 3. -----  
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- 4. -----  
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- 5. -----  
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6. With whom have you been living since your parent's death? (*find out if they moved around*)

Case NO	Places and people moved to	Kin/non kin

7. (*If parents were ill*) How did you experience your parent/s illness? (*probe for psycho-social and material effects*)

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2.-----  
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3.-----  
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4.-----  
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5.-----  
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**Inheritance**

8. What did you inherit from your parent/s after he/she died?

Case NO	Items inherited	Father/ mother

9. Did any other relatives inherit anything from your parents? If so, who are they? What did they inherit?  
*(State if those who inherited were the father/mother/sister/brother/child /cousin any other relative of the deceased in last column.)*

**Support networks**

10. Besides your current caregivers, who else is helping you and how are they helping you? (*Find out if it was father or mother's kin*)

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3.-----  
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4.-----  
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5.-----  
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**Hardships and problems**

11. What are the most difficult things about being without your parent/s?

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2.-----  
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3.-----  
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4.-----  
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5.-----  
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12. Who assists you with the following? (*Find out if it is a surviving parent, grandparent, uncle, aunt, sibling, cousin, other relative, NGO/CBO, members of the community, church, teachers.*)

**Parental monitoring and supervision**

13. Who do you inform/ask about the following?

Case No.	When you are sick	When you are going to be late	To go out with friends	People you can play or be out with	Permission to travel or live with another relative

**Stigma and Discrimination**

14. Do you feel that people treat you differently from other children? If so, how do they treat you differently?

1.-----  
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2.-----  
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3.-----  
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4.-----  
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5.-----  
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## Endnotes

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<sup>i</sup> In Namibia various modes of production co-exist. They range from hunting-gathering to subsistence peasant farming to industrial capitalism. This creates a fractured economy with different levels of specialisation, division of labour and social classes.

<sup>ii</sup> Methodenstreit (German) refers to the methodological dispute between Neo-Kantians and naturalists on whether the social sciences require different methodological approaches to the natural sciences. It also runs through the historical, classical and neoclassical economic debates on the role of values judgements in research and if value free or value neutral research is in fact possible. (Jary and Jary, 1991, pp. 409-410)

<sup>iii</sup> Consanguine families amongst the Nayar in India and Mundurucu of South America had rules of residence like consanguine families today where mothers, their children, other brothers and sisters share residence. This can by no means be used as proof of sexual relations between kin. Engels also sees the fact that the classificatory system does not distinguish between biological parents and aunts, uncles or cousins as proof that paternity could not be determined in societies at the lower levels of the evolutionary scale. He therefore fails to recognise the social construction of parenthood and that in many societies, particularly African societies the social functions related to motherhood are often shared by different women in a family, kinship group or community and hence no linguistic distinctions are made between adults who perform these roles.

<sup>iv</sup> Haviland. 1993. p 213 argues that in most human societies there are incest taboos that at the very least prohibit sexual relations between parent and child and siblings of different sexes. There may be a few exceptions to sibling incest rule amongst royalty/elite groups, for example in ancient Egypt, and the Inca Empire, to maintain the purity of the lineage. In Roman Egypt brother-sister marriages were common amongst the farming class, since property was inherited by both men and women, and therefore these marriages prevented the fragmentation of family holdings.

<sup>v</sup> Lee explains that while anthropologists use the term !Kung, the self appellation is Ju/hoansi, also at terms written as Zhu/twatsi.

<sup>vi</sup> bell hooks prefers to write her name without capital letters and this author respects this preference.

<sup>vii</sup> Population Census of 2001 indicates declines in marriage rates.

<sup>viii</sup> In Namibia various modes of production co-exist. They range from hunting-gathering to subsistence peasant farming to industrial capitalism. This creates a fractured economy with different levels of specialisation, division of labour and social classes.

<sup>ix</sup> Michael Foucault and Edwards Said both argue that every knowledge claim implicitly carries with it relations of power, for what stands as knowledge often depends on who says what and with what authority.

<sup>x</sup> Research done by Harvard University calculates that around 365 000 South Africans died premature deaths between 2000 and 2005 because of that government's refusal to provide ARV treatment. (ETV news 26/11/08)

<sup>xi</sup> Michael Foucault in a lecture reproduced in Morris and Patton (1977: 62) argues that the exercise of power is at the same time a site where knowledge is formed. Therefore (p64) the free floating scholar whose only function is dispensing truth disappears in favour of the person whose knowledge is authenticated by the power he/she holds. The same applies to institutions like the UN.

<sup>xii</sup> Edward Said (2003) explains that the facile notion of one world does not capture the complex unity of the globalised world.

<sup>xiii</sup> A plethora of research reports discuss in detail some of the conditions that OVC live under. They include the following reports by the Ministry of Health and Social Services:

First National Conference on Orphans and Vulnerable Children (2000)

Second National Conference on Orphans and Vulnerable Children (2002)

Third National Conference on Orphans and Vulnerable Children (2005)

In addition there are the UNICEF reports that include:

Children orphaned by AIDS (1999)

A situational analysis of Orphan Children in Namibia (2002)

State of the World's Children: Childhood under threat (2005)

State of the World's Children: Excluded and invisible (2006)

<sup>xiv</sup> In our research conducted in informal settlements on the outskirts of Windhoek we found that in all categories of sexual unions men reported higher levels of condom use than women because men have more control over it.

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Women reported a lack of decision making ability over condom use because of economic dependency, gender-based violence and the lack of female controlled safe sex technologies.

<sup>xv</sup> This was reported at October 2005 workshop on Women's Health by the co-coordinator of the AIDS Care Trust in Windhoek.

<sup>xvi</sup> The Namibia Household Income and Expenditure Survey 2003/4

<sup>xvii</sup> The enjabi system traditionally provided a way of compensating temporary shortages and where members of a community get together to assist families that have labour shortages with cultivation or harvesting.