



Joint Learning Initiative on Children and HIV/AIDS
JLICA

Learning Group 1 – Strengthening Families

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**QUALITATIVE ACCOUNTS OF FAMILY AND
HOUSEHOLD CHANGES IN RESPONSE TO
THE EFFECTS OF HIV AND AIDS: A
REVIEW WITH POINTERS TO ACTION**

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The Joint Learning Initiative on Children and HIV/AIDS (JLICA) is an independent, interdisciplinary network of policy-makers, practitioners, community leaders, activists, researchers, and people living with HIV, working to improve the well-being of HIV-affected children, their families and communities.

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Preface - Learning Group 1: Strengthening Families

The work conducted in Learning Group 1 was based on the fact that families, in all their many forms, are everywhere the primary providers of protection, support and socialization of children and youth, and families exert a very strong influence on children's survival, health, adjustment and educational achievement. This influence tends to be greater under conditions of severe strain, such as is caused by HIV and AIDS, particularly in the context of poverty.

In general, functional families love, rear and protect children and buffer them from negative effects. Functional families are those that have sufficient material and social resources to care for children, the motivation to ensure that children are nurtured and protected, and are part of a community of people who provide one another with mutual assistance. Family environments are especially important for young children. It is well established that multiple risks affect the cognitive, motor and social-emotional development of children and that the quality of parenting, assisted by intervention when needed, can ameliorate such impacts.

From the start of the epidemic, families have absorbed, in better or worse ways, children and other dependents left vulnerable by AIDS-induced deaths, illness, household and livelihood changes, and migration. Similarly, families have contributed, more or less successfully, to the protection of young people from HIV infection. Under the devastating effects of the epidemic, families need to be strengthened – economically, socially and with improved access to services – to enable them to continue, and to improve, their protection and support of children and youth. Families that neglect and abuse children need to be identified and social welfare services must be provided to them.

Families, extended kin, clan and near community are the mainstay of children's protection in the face of the AIDS epidemic - as they have been in poor countries under other severely debilitating social conditions, including war, famine and natural disaster. Only a very small proportion of AIDS-affected children are currently reached by any assistance additional to support they receive from kith and kin. The most scalable strategy for children is to strengthen the capacity of families to provide better care for more children.

The co-chairs, secretariat, lead authors and stakeholders of Learning Group 1 were guided in the work undertaken in the Learning Group by the following key questions. By and large, these are the critical research, policy and programme questions currently being debated in the field.

1. On which children and families should we focus?
2. What evidence is available on which children are vulnerable and what can be done to help them, and how good is the research?
3. What aspects of the HIV/AIDS epidemic impact on children, how and why?
4. How are families changing as a result of adult illness and death associated with HIV and AIDS?
5. In what ways are children's health, education and development affected by the HIV/AIDS epidemic?
6. What does knowledge and experience of other crises teach us about the AIDS response for children and families?
7. What can we learn from carefully evaluated family strengthening efforts in fields other than HIV and AIDS that can be usefully applied in hard hit countries in southern Africa?
8. What programmatic experience has been gained in strengthening families in the HIV/AIDS field?
9. What promising directions are there for the future and what do they suggest?
10. What mistakes have been made and what now needs to be done?

These questions form the structure of the integrated report. As indicated in the Preface, detailed data and references are to be found in the respective LG1 papers.

Twelve detailed review papers constitute the primary evidence base for the conclusions drawn and the recommendations made by Learning Group 1. The papers, their authors in alphabetical order, and their affiliations are listed below.

List of authors, affiliations and paper titles

Authors	Affiliation	Title
Adato, M Bassett, L	International Food Policy Research Institute (IFPRI) – United States of America	What is the potential of cash transfers to strengthen families affected by HIV and AIDS? A review of the evidence on impacts and key policy debates
Belsey, M	Consultant – United States of America	The family as the locus of action to protect and support children affected by or vulnerable to the effects of HIV/AIDS: A conundrum at many levels
Chandan, U Richter, L	Human Sciences Research Council (HSRC) – South Africa	Programmes to strengthen families: Reviewing the evidence from high income countries
Desmond, C	Human Sciences Research Council (HSRC) – South Africa	The costs of inaction
Drimie, S Casale, M	International Food Policy Research Institute (IFPRI), Regional Network on AIDS, Food Security and Livelihoods (RENEWAL), Health Economics and AIDS Research Division (HEARD – South Africa	Families' efforts to secure the future of their children in the context of multiple stresses, including HIV and AIDS
Haour-Knipe, M	Consultant – Switzerland	Dreams and disappointments: Migration and families in the context of HIV and AIDS

Hosegood, V	London School of Hygiene and Tropical Medicine (LSHTM), Human Sciences Research Council (HSRC) – South Africa	Demographic evidence of family and household changes in response to the effects of HIV/AIDS in southern Africa: Implications for efforts to strengthen families
Kimou, J Kouakou, C Assi, P	Ivorian Centre for Economic and Social Research (CIRES), Family Health International (FHI) - Côte d'Ivoire	A review of the socioeconomic impact of antiretroviral therapy on family wellbeing
Madhavan, S DeRose, L	University of Maryland – United States of America	Families and crisis in the developing world: Implications for responding to children affected by HIV/AIDS
Mathambo, V Gibbs, A	Human Sciences Research Council (HSRC) – South Africa	Qualitative accounts of family and household changes in response to the effects of HIV and AIDS: A review with pointers to action
Sherr, L	Royal Free and University College Medical School – United Kingdom	Strengthening families through HIV/AIDS prevention, treatment, care and support
Wakhweya, A Dirks, R Yeboah, K	Family Health International (FHI) – United States of America	Children thrive in families: Family-centred models of care and support for orphans and other vulnerable children affected by HIV and AIDS

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1. Introduction and conceptual framework

1.1 Introduction

Families and households are subjected to a number of social, economic, political and demographic challenges. In recent years, the AIDS epidemic has constituted a major challenge for already poor families and households due to its wide reaching social, economic and health consequences. Globally, it is estimated that about 33.2 million people are living with HIV, 22.5 million of whom are in sub-Saharan Africa (UNAIDS, 2007). South and East-Asia, Latin America and Eastern Europe are other geographic regions which are severely affected by the epidemic. In 2007, 2.1 million deaths were attributed to AIDS-related illnesses globally (UNAIDS, 2007). According to the 2007 UNAIDS report, 1.6 million or 76 percent of these deaths were in sub-Saharan Africa. It is estimated that more than 15 million children under 18 years have lost one or both parents to AIDS (UNICEF, 2008). The devastating consequence of HIV and AIDS is being seen through the prolonged illness and death of family and household members of prime working age which impacts on family and household livelihoods and the ability to provide for its members.

The impact of a shock like AIDS on families and households is not confined to the illness and death of those directly affected, it also has secondary implications for surviving family and household members. AIDS predominantly affects the economically active population which compromises the coping capacities of families and households. As economically active members become sick and are no longer able to work, household production and consumption decrease. The economic shock of AIDS threatens the integrity and welfare of families and households, and their survival as social and cultural units (Baylies, 2002). Thus, children living in households affected by AIDS face deepening poverty (UNICEF, 2008).

Despite the numerous challenges facing families and households, they continue to be the central organising unit of communities and societies and remain an important social security system (Ntozi & Zirimenya, 1999; Foster, 2000; Amoateng & Richter, 2003). Faced with pressure from the effects of HIV and AIDS, families and households will not necessarily have uniform trajectories. Some will collapse (and there are a number of parameters of collapse which will be discussed) while others will survive depending on varied factors, especially those relating to social capital and material endowment. The continuum of survival will also be explored.

1.2 Conceptual framework

This paper is a review of qualitative accounts of how families and households in southern Africa have changed, and are changing, as a result of the impact of AIDS. The purpose of the review is to provide pointers for action that will lead to actions to strengthen families and households facing pressure from the effects of the AIDS epidemic. The review starts from the premise that there is no universal domestic unit, and that functions performed by domestic units vary across space and time.

Families are social groups connected by kinship, marriage or adoption with clearly defined relationships, mutual obligations and responsibilities (Amoateng, Richter, Makiwane & Rama, 2004). Families can either be nuclear (a couple with or without children) or extended (multigenerational) in nature. While nuclear families have tended to occur among societies in the north and extended families remain predominant in the south (Hyde, 1993), it is important to note that several types of family and family organisations co-exist across time and space (Segalen, 1986).

This paper acknowledges that an understanding of households, based on co-residence, does not capture domestic units which may be structured differently. For example, in southern Africa, where employment-linked circular migration is still prevalent, an important household member may be non-resident (Wilk & Netting, 1984). Also, an extended family may be split across a number of households. Kayongo-Male & Onyango (1984) distinguish between *de jure* household membership – which includes household members temporarily absent - and *de facto* membership – referring to members actually resident at any one time in a household.

Families and households, like other social institutions, are dynamic, not static, entities. They change and adapt when faced with any threat, including disease and social disruption. However, change and adaptation are not necessarily successful.

In this review, qualitative accounts are understood to mean empirical and theoretical narratives and analyses of the impact of AIDS on families and households, of family and household responses to AIDS, and of how families and households are adapting to the changes engendered by the epidemic. This paper has strong links to Paper 1 by Sangeetha Madhavan *Families and crises in the developing world*; Paper 2 by Vicky Hosegood *Demographic evidence of family and household change*; Paper 3 by Mary Haour-Knipe *Migration and families affected by HIV/AIDS*; Paper 5 by Mark Belsey

The family as the locus of actions to protect and support children and Paper 9 by Scott Drimie *Families' efforts to secure the future of their children*.

1.3 Aim of the review

The aim of this review is to source and review qualitative accounts of how families and households are changing as a result of AIDS and what pointers for action can be derived from them. The review draws on accounts from a variety of contexts and explores the validity of the notion that the African family is disintegrating. In addition, the review seeks to make recommendations on how regional and cultural differences can inform the design of responses aiming to strengthen families and households. Although the review is wide-ranging, it focuses on southern Africa, the area with the highest HIV prevalence.

2. Methods

2.1 Methods for document search

This section outlines how documents for the review were sourced. Four approaches were used to search for documents for the review. Firstly, electronic databases and journals were searched using a combination of search terms. Keywords used in the search are: HIV, AIDS, family, household, impact, changes, responses, coping, and coping strategies. Electronic databases searched are as follows: African Journals Online, EBSCOHOST – Academic Search Complete, Family and Society Studies Worldwide, and Sociological Abstracts. These four databases index and provide abstracts of African and international literature including journal articles, books, book chapters, dissertations, and conference presentations in the social sciences. The records of EBSCOHOST – Academic Search Complete, for example, cover the period 1865 to the present. The journals, *Annual Review of Anthropology* and *Annual Review of Sociology*, were searched manually for documents. These two online journals index literature in anthropology and sociology and provide abstracts dating back to 1972 and 1974, respectively. In addition, these journals offer full-text access from the 2000 volume to the current volume.

Secondly, an extensive bibliographical database, maintained by the Child, Youth, Family and Social Development (CYFSD) research programme, on orphaned and other vulnerable children (OVC), was searched. CYFSD maintains a bibliographical

database which contains references relating to vulnerable children, HIV and AIDS, and families. This database was searched using keywords mentioned above. Thirdly, reference lists of sourced articles were used as secondary sources of documents. Finally, authors of papers in the Strengthening Families Learning Group set up informal networks through which grey literature was sourced and shared.

The search yielded 1 757 hits - most of which were purely quantitative studies thus irrelevant for purposes of this review. For example, some of these studies had used population and household census data, and demographic surveillance data. It should be noted that some studies using a combination of qualitative and quantitative data collection and analysis techniques are included in this review. Other studies considered irrelevant to the review were those focussing on individuals - for example, how individual women affected by AIDS cope with depression and stress. Eighty eight (88) documents form part of this review.

2.2 Methods for document review

Documents included in this review present qualitative data - particularly anthropological, ethnographic and sociological accounts of how families and households are conceptualised, how a stress such as AIDS is impacting on families and households, how families and households are responding to AIDS, and how the concept of coping is understood. These documents are available in electronic or print format.

2.3 Key questions of the review

Some of the key questions which this review seeks to answer are as follows:

- How are family and household currently conceived in a variety of contexts? For example, in African as compared to Asian, Latin American, and Western contexts.
 - What contextual factors inform these conceptions?
 - What roles do kinship, culture, economics, politics, and geography play in the organisation of family and household?
 - What is the value placed on children, grandparents and other family members, paternal and maternal?
- What do we know about how AIDS impacts on families and households?
- How are families and households responding to AIDS?
 - Is there a continuum of responses?

- Are these responses common to other stresses, such as drought, labour migration, and the like?
- Which contextual factors mitigate the impact of AIDS on families and households?
 - The influence of cultural practices such as widow inheritance
 - Living arrangements
 - Kinship networks
 - Family and social capital.
- Is the family a safety net coping or is it on the verge of collapse?
 - What is meant by coping?
 - Collapse and the social rupture thesis.
- What are some of the practical strategies that can strengthen families and households to better respond to the impact of AIDS on children, in particular?

3. Results and discussion

Studies reviewed here cover the following areas: the concepts of family and household; the impact of AIDS on families and households focusing on emerging household types, parental loss, changing fosterage practices, and decisions regarding starting families; a range of family and household responses and how stigma impacts on these; and the concept of coping in a context of AIDS.

Understanding the concepts of family and household

Yanagisako (1979:162) made an interesting observation that domestic units, ordinarily referred to as families in Maliwonski's time, have come to be categorised into families and households.

3.1 Family

A family usually consists of a "group of two or more people" who may be linked by birth, marriage or adoption (Belsey, 2005:11). Families are characterised by hierarchical relationships with members having differential privileges and duties, who are bound by a sense of togetherness. Although a nuclear family structure seems to be replacing extended families due to the demands of modernisation and urbanisation, in most societies these family types are not mutually exclusive (Segalen, 1986; Ntozi *et al.*, 1999).

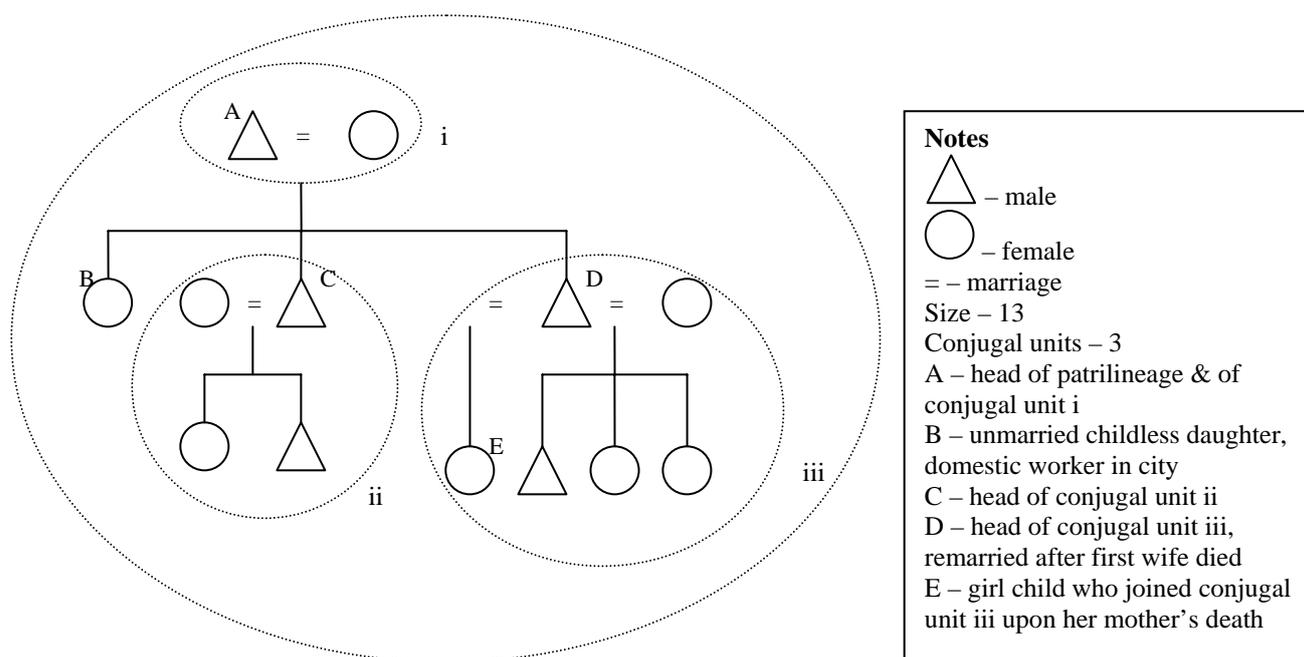
It is accepted that families take various forms in different contexts and across time as a result of the family life cycle and changes in the broader environment (Hyde, 1993). As such, family theorists have long accepted that families are structured, organised and function differently in different settings.

3.2 Households

Although kinship and locality are key characteristics defining family and household membership respectively (Yanagisako, 1979; Russell, 2004), households encompass more than shared residence. Household members also contribute to the day-to-day running of the domestic unit – e.g. distribution of resources, preparation of food, and childcare.

Household boundaries tend to be fluid and family structure complex (Young & Ansell, 2003a). For example, members of an extended family may belong to two or more nested households. Figure 1 below shows three conjugal units, within a single extended family unit. Unmarried daughter B, heads of conjugal units ii (C) and iii (D) are migrant workers - i.e. hold *de jure* membership – and send remittances which sustain the rural-based extended family.

Figure 1: An extended family consisting of a number of nested conjugal units



3.3 Family life cycle or development

Acknowledging that family theories abound, William Goode's work on families in the 1960s is still considered seminal. According to Goode (1982: 9), most domestic units can be considered families, "more or less", and family life is closely related to life cycle stages.

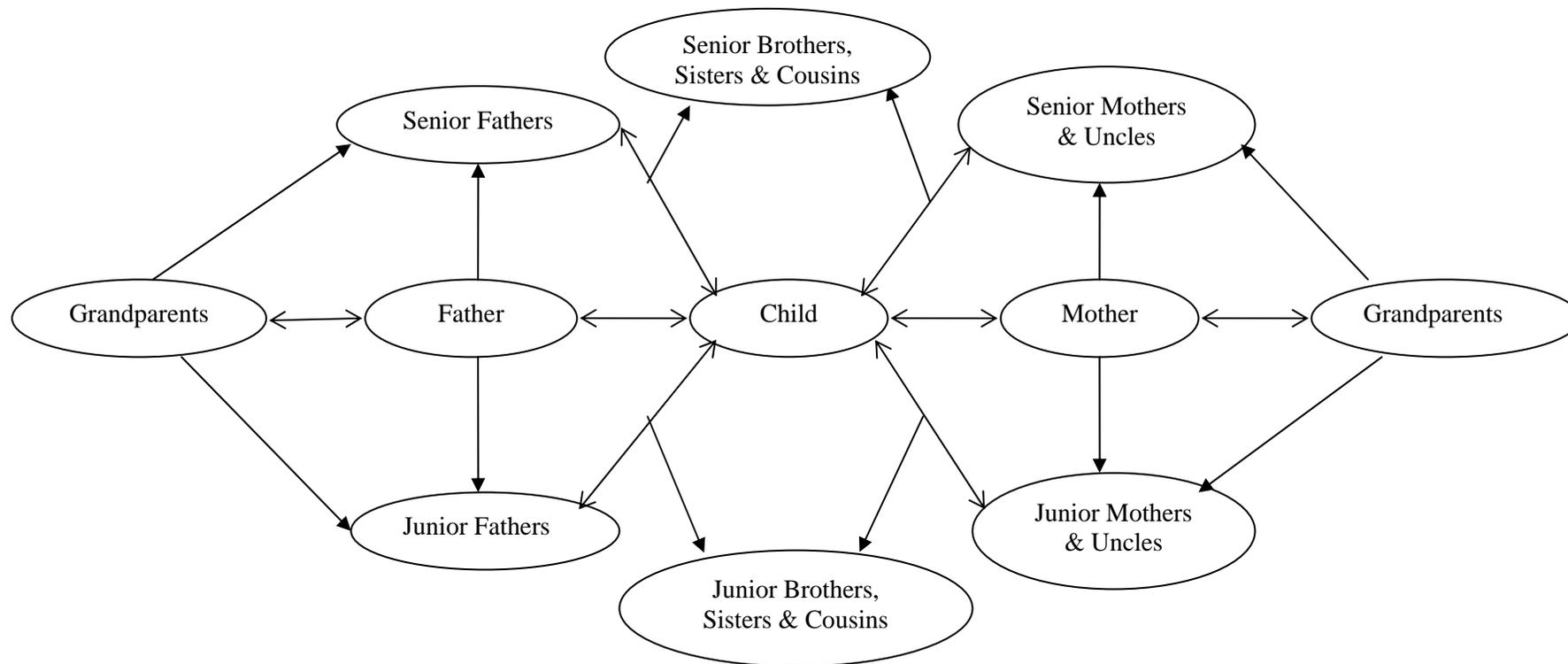
A domestic unit may be small or large depending on the developmental stages or life cycle of its members. For instance, a newly married couple, in settings where neolocality is the norm, will set up their own household without children, move on to have children who start and complete school, become young adults, get married and set up their own independent households. Ailing and/or retired grandparents may be taken in. Where spouses remain married until one spouse dies, they have completed the family life cycle. Although ailing and/or retired parents may be taken in at some point, this type of family is premised on a conjugal couple forming their own independent household. In this instance, family and household overlap, which is the case in most societies in the west.

Within a multigenerational household, as in Figure 1 above, the father or eldest male is the head of the patrilineal homestead consisting of his children and his children's

children. Upon marriage, because of patrilocality, sons will set up residence with or near their lineage, have their own children who are brought up with and by extended kin. The family life cycle continues, as parents age, their children and children's children co-reside in one patrilineal extended household. This situation depicts family and household organisation in the south.

In most of sub-Saharan Africa, family depicts more than biological parents and their offspring. For example, a father's brothers or a mother's sisters are classified as "senior" and "junior" fathers or as "senior" and "junior" mothers, depending on whether they are older or younger than a child's biological parents (Chirwa, 2002:98). In this context, a child grows up amongst many fathers, mothers, brothers and sisters who are obligated to support and protect one another (Chirwa, 2002; Verhoef, 2005). This characterisation of a family denotes kinship, long-term commitment and security (Preston-Whyte, 1978). Figure 2 below is a characterisation of a family in Malawi, by Chirwa (2002:99) which is typical of families in southern Africa. It should also be noted that responsibility for the care of orphaned children follows the kinship hierarchy depicted in Figure 2 below.

Figure 2: Characterisation of a southern African family (Chirwa, 2002:99)



Among Zulu-speaking people in South Africa, family relations are characterised similarly as a Malawian family depicted in Figure 2 above. A father is called *baba*, a father's older brother is *babomkhulu* or *babomdala* (which is equivalent to Chirwa's senior father), and a father's younger brother is *babomncane* (i.e. a junior father). A child will call all his/her father's brothers *baba*. All fathers are the obvious brothers, according to Oleke, Blystad & Rekdal (2005), who are expected to beget children on behalf of their brother - should the brother fail to do so - in order to continue the family line. In the case of their brother's death, obvious brothers are customarily obligated to take primary responsibility for the care and support of their deceased brother's wife and children.

Although in some contexts in southern Africa the use of uncle and aunt is common, these are usually reserved for mother's brother and father's sister respectively. There is generally a special relationship between an uncle and a nephew or niece, with the mother's brother expected to grant his sister's child special privileges. According to Fortes in Radcliffe-Brown & Forde (1950:270), "a good uncle will help his nephew, e.g. by paying for his schooling or setting him up in business".

3.4 Family functions

The family has always had productive, reproductive and protective functions (Belsey, 2005). That is, families provide food and shelter, share domestic labour, distribute family goods and resources, socialise the young, make decisions regarding access to health and educational opportunities, and transfer cultural and moral traditions from one generation to the next (Belsey, 2005:16). The Parsonian view is that the family also produces individuals fit for the society – hard working, honest, persevering, and considerate of others (Parsons, 1979). In addition, families play a protective function. However in some societies, such as the Nayar of India, a nuclear family does not have productive, protective and socialisation functions because married couples do not co-reside nor is the husband expected to provide for his wife and children (Gelles, 1995).

Although families and households evolve over time due to cultural, economic, political, social and technological influences, they continue to be an important safety net which is expected to protect members in times of crises and shocks. These crises and shocks include illness, death, divorce, natural disasters like floods and droughts, economic hardship, and political upheavals.

Kayongo-Male *et al.* (1984) argue that in African families, the reproduction of offspring outweighs any other family function. As such, Bateman (1996) proposed that “what people regard as their family” be taken as such, particularly by outsiders. This is in line with Malinowski’s argument that a study of the family, particularly in societies different from our own, should be premised on an understanding that “the essential features of the individual family ... depend upon ... the conditions of life therein” (Malinowski quoted in Yanagisako, 1979:161).

3.5 Role differentiation

In most families, a father is traditionally the head and provider – plays a public role - while a mother is the carer and nurturer – takes on a more private role. However, role differentiation may vary depending on household type e.g. whether it is a multigeneration, nuclear, dual income, same sex or single-parent household. Children, older persons and individuals with disabilities are usually dependents in both nuclear and extended families. However, in African families, children are viewed with pride as they guarantee continuance of the family line, while grandparents support the middle generation in the upbringing of grandchildren (Ntozi *et al.*, 1999).

As stated earlier, childcare and socialisation tend to be a collective responsibility shared amongst kin in extended families rather than that of biological parents alone, as may be the case in conjugal families. However, Verhoef’s (2005) profiling of extended family childcare arrangements has shown that some of these arrangements are fraught with difficulties – see below.

3.6 Differences in domestic organisation

Yanagisako (1979) characterises differences in family and household organisation as being across contexts and time. These differences are influenced by demographic, economic and other social processes. For example, AIDS-related mortality, currently high in sub-Saharan Africa, may be shaping the composition of households and families. Although kinship customs such as child fosterage offer protection to children whose biological parents have died, loss of economically productive adults puts strain on livelihoods and impacts on the organisation of domestic units. Therefore, household size may fluctuate in order to relieve strain on weaker households.

Differences in family and household composition can also be explained by differences in property redistribution between and within societies. In societies where only men have rights to family property, a wife (and her children) may not own her matrimonial home after her husband's death – unless she agrees to be inherited by an obvious brother. Thus, she may have to return – with her children - to her maternal home which may result in the dissolution of her household.

Labour requirements also impact on the size and type of domestic groups. Migrant workers, for example, hold dual household membership – they are *de jure* members of their rural households while also being *de facto* members of urban households. Rural households may shrink when able-bodied adults migrate to cities, and expand during the holiday season.

4. Impact of AIDS on families and households

The impact of AIDS on families and households cannot be separated from the broader changes in economic and social structures that are occurring independent of the AIDS epidemic (Barnett & Whiteside, 2002). Many of the communities affected by HIV/AIDS are simultaneously faced with high levels of poverty, and some with drought and other natural disasters, war and conflict. Most have experienced dramatic changes over the last century as cash economies became the norm, and labour migration increased.

Gwako (1998) and Cross (2001) contend that the emotional impact of AIDS on families and households usually goes unnoticed. For example, uncertainty felt by a child upon parental death, a woman losing love and companionship when her husband dies, a household losing an income earner, or a man losing face due to failure to adequately provide for his family. A study, conducted in Bangalore district in southern India, by Krishna, Bhatti, Chandra & Juvva (2005), reports of individuals contemplating suicide upon finding out they were infected with HIV - in order to protect their families from stigmatisation and discrimination. These individuals felt they had shamed their families.

AIDS in combination with other socio-economic influences impact on how households function, contributing to the emergence of 'new' family and household types which may not have been common in the past, children losing parents and

requiring care and support by the extended family, shifts in fostering patterns, and to delays in making decisions regarding marriage and having children.

4.1 Impact of AIDS on household functioning

The epidemic proportion of AIDS is mostly evident in the prolonged illness and subsequent death of the income earning generation – which is usually followed by role reversal and overload within households. When the middle generation is no longer able to work or when they die, grandparents may have to take up the role of primary caregivers to their grandchildren - instead of being cared for.

Shifts can also be seen in the division of labour and allocation of responsibilities and resources within households. For example, healthy family members may have to shoulder an increasing share of responsibilities, because they have to balance paid employment and caregiving – which limits their participation in social networks and their ability to tap into these networks for support (Songwathana, 2001; Krishna *et al.*, 2005).

Also, wives may have to take up paid employment - when husbands are incapacitated – in order to secure household livelihood. In other instances, children may be neglected, as household attention and resources are allocated to meeting the health needs of sick adults than the educational needs of children. This was reported by Songwathana (2001) and Krishna *et al.* (2005), based on their research on family caregiving in Thailand and India, respectively. Furthermore, children may have to assume adult roles – e.g. seek employment - in trying to secure household livelihood.

4.2 Emergence or re-emergence of household types

Madhavan (2004) asks a pertinent question whether the situation of children affected by AIDS, in South Africa, is indeed different from that of children living under *apartheid*. Migratory labour patterns saw children living in stretched – mostly matrifocal - households, left in the care of grandparents, or being fostered by different kin as and when required. While acknowledging that children have always been cared for by their grandparents, it is the permanence of such living arrangements which may be peculiar to the epidemic. As such, grandparents are currently finding themselves having to resume primary and permanent parental responsibilities when the middle generation dies. It is also important to note that

some grandparents may no longer be able to fulfil the role of primary caregiver as they may be ailing themselves, and/or have limited or no access to financial and psychosocial resources (Aspaas, 1999).

Sekokotla & Mturi (2004) in their study on the impact of AIDS on families found that elderly caregivers take on multiple roles as primary care givers, homemakers as well as income earners in such living arrangements. Ntozi *et al.* (1999) further mentioned that grandparents – as primary caregivers - also have to make most decisions about the care of their grandchildren. Amoateng *et al.* (2004:47) observed that the illness of the prime-aged individuals can affect the health state of and well being of the elderly as a result of depletion of household resources, additional physical work and the stress of coping with bereavement and the care of young children. Thus, AIDS may exacerbate poverty as households lose their livelihoods (Richter, Manegold & Pather, 2004). Grant & Palmiere (2003) regard the loss of income as an important determinant of the impact of the disease on the household.

A family form associated with the epidemic proportions of AIDS is the phenomenon of households with children only and those headed by young adults (Mturi, Xaba & Sekokotla, 2005). While death of a significant adult will be devastating to a child, children affected by AIDS do not necessarily have uniform trajectories. Some may be fostered by extended kin, while others may be left to stay in their parental home with regular visits and support from kin and kith. There are however some children who may find themselves on their own without adequate adult support and supervision. These variations need to be acknowledged in programme development.

Foster & Williamson (2000) state that children from families with little regular contact with relatives may find themselves abandoned if they are orphaned and the eldest sibling is likely to take care of his/her younger siblings. This situation begins for many of these children while their parents are still alive and have developed symptoms of the disease. Assumption of adult responsibilities, by children, may affect their school attendance, for example.

A number of concerns have been raised about the current research exploring the emergence of 'new' household types. These concerns are that intergenerational child care has always been a feature of extended families, child-only households may be an interim measure while a decision about orphaned children is being made, and that there is a rural-bias, with studies of household change tending to have been done in

rural areas (Nkurunziza & Rakodi, 2005). Speculating about why there is a rural bias, Barnett *et al.* (2002) suggest it may be because of a desire by mostly western researchers to see the 'real' Africa and their subsequent focus on rural areas.

The need to link the impact of AIDS on households and families needs to be tied closely to an understanding of other stresses such as migrant labour, the cycle that households go through and their specific resources and contexts within which they are located (Murphy, Harvey & Silvestre, 2005; Barnett *et al.*, 2002). These gaps in the literature broadly highlight issues which ethnographic research can cover in the depth and detail needed.

4.3 Orphaned children

In contrast to the limited studies looking at the emergence or re-emergence of certain forms of households, there is a rich vein of ethnographic and qualitative research on parental loss, and the provision of care for children who have lost parents.

Two approaches to understanding childcare in a context of AIDS are typically offered. In line with much research on families in 'developing' countries, these revolve around the role of the extended family in the provision of care.

4.3.1 Social rupture thesis

The first approach is the 'social rupture' thesis (Chirwa, 2002), which suggests that the extended family cannot cope with the demands currently placed on it by childcare (Cross, 2001). Children in this model find themselves excluded from relationships with kin and other family members and are forced to form their own households (Chirwa, 2002). In cases where children are taken in by their front-line relatives, they are reminded of their inferior position within their receiving households when they are allocated more household tasks, receive less food, are bought second-hand clothing, and sent to different schools (Abebe & Aase, 2007).

The 'social rupture' thesis implies that the family disintegrates under the strain of AIDS; however it misses the diversity of households, and the varied and nuanced nature of childcare and fostering arrangements (Foster, 2000; Chirwa, 2002; Meintjes & Giese, 2006; Abebe *et al.*, 2007).

Furthermore, this understanding denies the dynamism of the family to evolve and proactively respond to the demands placed on it, and also the role that social relationships and processes play in children's lives and experiences (Chirwa, 2002). As other studies recognise, the extended family has always been changing and adapting to broader shifts in patterns of labour migration, the emergence of the cash economy, urbanisation, famine, war and political change (Foster, 2000; Madhavan, 2004; Nyamukapa & Gregson, 2005; Abebe *et al.*, 2007).

4.3.2 Fluidity and dynamism of family relationships

The second approach recognises that the family is a fluid set of relationships that is constantly evolving to meet the demands placed upon it and that in the majority of cases, social rupture is not actually apparent (Chirwa, 2002; Abebe *et al.*, 2007). Based on his research on the care of orphaned children in Malawi, Chirwa (2002) states that innovative and alternative childcare strategies are emerging in response to the epidemic.

Similarly, Kuo (2007), using her work in KwaZulu Natal, South Africa, speaks of an expanding conception of family – to include both kin and kith - and a rearrangement of family roles and responsibilities. As such, family and the notion of relatedness is being reconfigured to include a wider network of kin and social relations. In this study, there were reports of neighbours looking after or taking in orphaned children. According to Kuo, this shows that families – in their broadest sense – are finding dynamic ways of responding to the epidemic.

4.4 Polarised view of extended family childcare arrangements

Abebe *et al.* (2007:2060) see this “polarised” view of childcare arrangements as limited as it downplays the differential impact of the epidemic on individual households and individual household coping capacity. Thus, they distinguish between extended family capacity to provide materially for children (economic capacity), willingness to care and provide psychosocial support (emotional capacity), and capacity to equip children with socially and culturally appropriate skills (social capacity). Instead of clustering extended households as collapsing under the strain of the epidemic, it is critical to recognise that some households may be emotionally and socially capable to care for children while not able to meet the material needs of children.

4.5 Profile of extended family childcare networks

While acknowledging the dynamism of family childcare arrangements, Verhoef (2005) cautions against idealising or romanticising extended family networks. She calls for a reality check and for acknowledgement that some childcare arrangements may be far from their cultural ideal. Based on her work among the Nso' of Cameroon, Verhoef (2005) distinguishes between ideal family networks – within which children are raised collectively by willing kin, and the everyday reality of raising children – which may be characterised by distrust and disagreements over childrearing practices. Using a case study approach, Verhoef (2005:375) profiled three childcare arrangements – i.e. “the joint venture, the ambivalent takeover and the tug-of-war”.

A joint venture - usually an equal partnership between maternal relations - had mothers and caregivers making decisions jointly about their child. It is thus not surprising that children finding themselves in this living arrangement were happy. In an ambivalent takeover, a mother was usually judged unfit due to a premarital pregnancy, unemployment or illness. Thus, a relative or non-relative felt obligated to remove a child from what was deemed an inappropriate living arrangement. A tug-of-war arrangement was characterised by family politics, with children being caught in fights between their mothers and caregivers. Both the ambivalent takeover and tug-of-war fostering arrangements present a different picture from that of reciprocal and collective childrearing, thought to be the forte of extended families. In cases where parents have died, disputes over child custody and multiple migrations by children may be indicative of tug-of-war fostering arrangements.

4.6 Assessing strength or weakness of the extended family network

Foster (2000), in his review of published studies of family responses to orphaned children, proposes indicators of the strength or weakness of the extended family as a safety net. Factors reflecting extended family strength include widow inheritance, purposive child fostering, and maintaining regular contact with relatives. For example, children of migrant workers – who have irregular or no contact with their kinsmen – may be received reluctantly upon the death of their parents.

On the other hand, minimal support from relatives, emergence of households headed by children, household dissolution and child migration indicate that the extended family is weakening as a safety net. Foster (2000:3) goes on to say that the extended

family safety net tends to be “better preserved” in rural communities, whereas it is less intact in urban communities. While Madhavan (2004:1449) acknowledges that Foster’s conceptualisation of the strengthening or weakening of the extended family is innovative, she finds this conceptualisation “somewhat simplistic and not particularly sensitive to differences in cultural contexts in Africa.”

It should also be noted that household fragmentation does not necessarily mean the extended family network is collapsing. For example, a mother may migrate to the city to look for employment after her husband’s death in order to provide for her children, with children either left alone for periods of time or being sent to live with relatives. As household circumstances change – e.g. subsequent illness or death of a breadwinner in a fostering household – relatives may no longer be in a position to meet a fostered child’s everyday needs, hence they may send the child to live elsewhere. According to Ansell & Young (2004b), sharing childcare among front-line relatives can potentially cement kin relationships and contribute to the strength of extended family network as a critical safety net.

4. 7 Shifts in fostering patterns

Older ethnographic literature on the provision of care for children in the extended family suggested that there were dominant relations of care – children went to a fixed set of relatives. Also, Aspaas (1999) notes that, throughout sub-Saharan Africa, the extended family has always provided a safety net for children - particularly in times of crisis. Purposive or voluntary fostering - the practice of sending children to live elsewhere – has always been common in extended households (Goode, 1982; Goody, 1982; Kayongo-Male *et al.*, 1984; Ansell & van Blerk, 2004a; Madhavan, 2004; Sekokotla *et al.*, 2004).

Child fostering can serve a number of functions. Children can be sent to ‘foster-parents’ in order to strengthen relations or friendships, to facilitate access to better educational opportunities, to offer companionship to childless couples or grandparents, to offer additional labour when needed, to instil discipline in a difficult child, and to reduce strain on limited household resources (Goody, 1982; Ansell *et al.*, 2004a; Madhavan, 2004).

A number of studies have documented a shift from purposive to crisis fostering – e.g. Madhavan (2004) in South Africa and Oleke, Blystad, Moland, Rekdal &

Heggenhougen (2006) in northern Uganda. Although children who have lost parents are still cared for by the kin network, they now have to live permanently with their kin. Another shift documented is that children are finding themselves in the care of their maternal kin rather than their paternal kin in traditionally patrilineal societies (Ntozi, 1997; Ansell *et al.*, 2004a; Oleke *et al.*, 2006). In societies where property is inherited through the patrilineage – as is the case in most of sub-Saharan Africa – children in the care of maternal kin grow up unsure about where they belong and what their rights are, particularly relating to claiming their property rights (Oleke *et al.*, 2005).

Another shift in the provision of child care has been reliance on grandparents as primary caregivers. Foster *et al.* (2000), in their overview of the current literature on sub-Saharan Africa, argue that a shift is seen from reliance on uncles and aunts to grandparents and other relatives. Safman's (2004) work in Thailand also notes that children who have lost parents are being cared for by grandparents. Numerous other studies document this trend (e.g. Hosegood, Preston-Whyte, Busza, Moitse & Timaeus, 2007; Schatz & Ogunmefun, 2007) towards the provision of care by grandparents as the primary carer is no longer available.

While most studies emphasise that change is the key dynamic for the provision of care for children within the extended family, research by McGrath, Ankrah & Maxine (1993) and by Madhavan (2004) argues that the impact of AIDS on the family may be to bolster traditional norms of care provision. However, other work suggests that traditional patterns of family construction also play a particularly important role in the provision of care. Nyambedha, Wandibba & Aagaard-Hansen's (2001) work in Kenya, suggests that the Luo's system of polygamy played an important role in supporting children whose parents have died.

Other studies focusing on the provision of care to children have talked to women living with terminal illnesses to explore who they think will take care of their children. In contrast to the studies discussed above, which highlight the role of the extended family (in its numerous changing forms), these emphasise that the mothers are unsure of who will provide care. One study in rural Mozambique spoke to women with terminal illnesses, predominantly AIDS, about their concerns for the children they were leaving behind. The role of the extended and immediate family in the provision of care for their children was noticeably limited, with a great focus on the role of the Mozambican state (Roby & Eddleman, 2007). This seemingly

contradictory outcome – that the family network is not seen as able to provide care, while other studies suggest it will - needs to be explored further.

In exploring extended family capacity to care for children whose parents have died, attention seems to be paid on willingness rather than on the interconnectedness of willingness and the economic capacity to care. For example, an adult's willingness to care for a deceased relative's child may be suppressed by his/her difficulties in providing for the basic needs of his/her children. Poor households, although willing, may find it difficult to take in additional children. Furthermore, the various factors influencing child fosterage should not be downplayed. Girls may be taken in to primarily assist with household chores and the care of elderly or sick persons, while boys are more likely to be fostered under crisis conditions (Ansell *et al.*, 2004a; Richter *et al.*, 2004).

4.8 Decisions of marriage and children

The impact of AIDS on the decision to form households – either through marriage or through the desire to have children – has had little attention in the ethnographic literature. Such decisions cannot be disassociated from broader cultural, economic and social norms and structures, and also how AIDS is understood. The decision about whether to form new households, have children and dissolve households is crucial in understanding the impact AIDS is having on households and the family.

While quantitative research may offer broad trends, ethnographic qualitative work offers a way to understand what is happening. The literature is sparse but suggests that AIDS does impact on these decisions. The early work by Barnett & Blaikie (1992) in Rakai, Uganda, suggested that people were delaying getting married as the impact of AIDS became more apparent. However, such an understanding was difficult to arrive at as qualitative research on this question was more anecdotal than rigorous.

Baylies (2002) looks at women's decisions to have children in Zambia and whether this has impacted on family size. Her work suggests that while women may have been concerned about AIDS, they did not link this to conception. Baylies' analysis suggests that women's control of reproduction was limited due to economic and gender inequalities. Those women who said that they would have fewer children, did so not because of concerns about HIV-infection, but because they were concerned about the number of children they would leave if they died. The fewer children left behind the

more likely they would get good care, was their rationalisation. Although Baylies' analysis is important, it is limited as it is based on women who did not know whether or not they were living with HIV.

Other studies, however, have looked at the decision to have children with couples where at least one partner is living with HIV. D'Cruz (2002) looks at this question in India. Seven couples, with at least one person in each couple HIV-positive, were interviewed and were asked about decisions to have children. For six of them they had decided not to have children, the seventh couple were actively trying for children.

In a similar vein Cooper, Harries, Myer, Orner & Bracken (2007) explore South African women's and men's decisions around childbearing – all of whom were HIV-positive. This research found that although there was strong community disapproval about having a child knowing you were HIV-positive, for the women, the desire to have a child was bound up closely with the identity of being a woman and the attendant social status derived from having children. As Cooper *et al.* (2007) point out, access to antiretroviral treatment and to treatment for the prevention of mother to child transmission of HIV, may change the broader framework in which the decision to have children is made.

Decisions to marry and have children are rooted in broader social and cultural issues, which the AIDS epidemic challenges.

5. Family and household responses

A number of mechanisms may be used by households and families to mitigate the impact of a shock such as AIDS. These mechanisms may be pre-planned and have been used in other situations of household and family adversity. However, due to the nature of AIDS, these strategies are often less well formulated and often reactive rather than proactive (Sauerborn, Adams & Hien, 1996). Responses from households and families are also tied into the broader changes that are seen in the nature and composition of these (Ellis, 1998).

Family and household responses are influenced by contextual factors such as cultural understandings of AIDS, strength of connectedness with kin and other social networks, gender and patriarchy, customary patterns of childcare, and access to resources and livelihoods. It is critical to acknowledge difficulties households

experience in responding to the epidemic. Problems such as discrimination, stigmatisation and uncertainty about the future may influence the care provided to a household member living with AIDS (Castro, Orozco, Aggleton, Eroza & Hernandez, 1998).

According to Castro *et al.* (1998:1475), a family affected by AIDS goes through four identifiable life or career stages. These are a life before HIV, finding out about a member's HIV status, living with a person with HIV or AIDS, and surviving the death of a family member from AIDS. Each of these stages brings its own psychological burdens, and influences family functioning. For instance, a family affected by HIV, in China, experiences shame, particularly from outsiders. To avert losing face and being discriminated against, a family may stick together in order to keep this family secret and to also save face (Li, Wu, Wu, Sun, Cui & Jia, 2006).

5.1 Impact of stigma on household and family responses

In many contexts - because of poverty, sexual taboos, fear and myths around AIDS, and gender inequalities - stigma surrounding AIDS is crucial in shaping and constraining household and family responses (Campbell, Foulis, Maimane & Sibiya, 2005).

Household and family responses are shaped by social constructions of HIV infection - whether it is seen as emanating from an individual's own behaviour or as external and beyond an individual's control (Baylies, 2002:618). Distinction can be made between individuals who get infected through their own socially unacceptable behaviour - such as homosexuality, and those classified as innocent victims - children, for example. Castro *et al.* (1998), in their work in an impoverished community and a gay community in Mexico, found that individuals seen as innocent victims received better care from family than those considered deviants.

The studies reviewed here, suggest that many people did not know their HIV-status, and that when they found out they were HIV-positive, they chose not to disclose to their immediate family (Caldwell, Caldwell, Ankrah, Anarfi, Agyeman & Awusabo-Asare *et al.*, 1993; Castro *et al.*, 1998). Fear of rejection by their family, especially when HIV-infection was linked to 'culturally-taboo' issues such as male homosexuality meant that individuals often hid their status until physical signs of

AIDS started showing (Castro *et al.*, 1998). In such instances, a family could not prepare itself adequately for living with a person with AIDS.

When a person is living with HIV, the household and immediate family try to limit who knows about the diagnosis. Krishna *et al.* (2005), in their study of household responses in India, note that a key concern of the household is limiting the knowledge of an HIV diagnosis to only key individuals. In cases where a family member living with HIV is also homosexual, information management also serves as a family's attempt to control the sexuality of this member. Fear of stigma minimised who they told, and thus limited the possibility of broader responses by the extended family.

A similar finding is reported in China, where Li *et al.* (2006) note that initially the immediate family did not respond to the needs of the person living with HIV, because of the stigma and shame associated with being HIV-positive, and a fear of social censorship (Castro *et al.*, 1998). But over time, the immediate family dealt with this and provided a pro-active response in the form of care and support. As Baylies' (2002) work in Zambia suggests, it is often individual households that bear the brunt of responding to the impact of the epidemic, rather than the extended family and community, because of the stigma associated with AIDS.

While acknowledging that stigma may undermine positive household and family responses to the epidemic, Castro *et al.* (1998) rightly warn that financial and time constraints may also stop people from visiting, for example. Therefore, failure to visit should not necessarily be construed as inaction by or collapse of the extended family network. Furthermore, the pain, despair and distress experienced in seeing a family member progressively dying from AIDS should be acknowledged. This emotional conundrum may leave family members uncertain about what to do - some of whom may even distance themselves from the person living with AIDS, as a way of dealing with the situation.

5.2 Inter-household and family transfers

Another important response within the extended family is transfers. Transfers can be in a range of forms, from cash and gifts, through to the provision of care (which will be considered below). While some studies have pointed to the role of transfers within families as an important response to AIDS in a household, the literature is less clear.

Baylies (2002) suggests that these 'safety-nets' are liable to crumble and fragment easily and are uneven in their availability to households, with richer households often having more than poorer households.

A similar issue is highlighted in India, with the extended family not only visiting less but also sending limited support to the household in the form of cash, if they know that a person in it is living with HIV (Krishna *et al.*, 2005). Grant *et al.*'s (2003) work in urban Zimbabwe highlights the role of stigma in limiting broader family support for the household, but suggest that after an AIDS-related death, cash transfers are likely to occur. However, they stress the wide variety in value of these transfers and the fact that these transfers are generally short lived, lasting an average of six months only.

Similar findings were also seen in Hilhorst, van Liere, Ode, & de Koning's (2006) work in Nigeria and Baylies' (2002) work in Zambia, where households with greater social capital - more dense networks - had more support from families. As such, Baylies (2002:622) portrays the extended family network as a "safety net with holes", because it offers differential protection to individuals and households in need – depending on household or an individuals' status within the network. Closeness of kinship ties and the subordinate role of women, for example, also contribute to the type of support an individual can access in times of crises. For example, a widow may be neglected by her in-laws after her husband's death as her caregiving services may no longer be needed, if she is blamed for her husband's death and/or is seen as an outsider (Bharat & Aggleton, 1999).

5.3 Widow inheritance

The practice of levirate marriage – or widow inheritance - common in most of eastern and southern Africa prescribes lines of responsibility for wives (and their children) after spousal death. Upon spousal death, a deceased husband's kin usually hold a meeting to discuss which of the deceased's obvious brothers will inherit his wife and children. In Figure 1 above, D is potentially an obvious brother, should C die and vice versa. That is, D would be expected to assume responsibility for C's wife and two children.

In rural Manicaland, Zimbabwe, a widow could decide not to be inherited, without this necessarily impacting negatively on her own and her children's welfare

(Nyamukapa *et al.*, 2005). Thus, responsibility for her children would be divided among paternal kin who are willing to care for them – e.g. one relative may be tasked with providing money to ensure household survival, while another may be tasked with paying school fees or being a father figure to the children. Gwako (1998) had earlier painted a different picture among the Maragoli of western Kenya - a widow who resisted inheritance by her husband's brother could be asked to leave her matrimonial home empty-handed.

A number of studies have noted a decline in the practice of widow inheritance, and have attributed a number of factors to this (Gwako, 1998; Ntozi *et al.*, 1999; Nyamukapa *et al.*, 2005; Oleke *et al.*, 2005). While the Luo and Maragoli of western Kenya, and the Shona of Zimbabwe still practise levirate marriage, changes in this customary practice have been attributed to the changing status of women, women's improved access to and control of resources, increasing costs of living, prevalence of HIV, the adoption of Christian values, and the disappearance of eligible classificatory brothers.

The gradual disappearance of obvious brothers due to war, violence and AIDS is linked to the discontinuation of the practice of widow inheritance. In the Oleke *et al.* (2005) study, elder informants lamented the disappearance of this customary practice because it was seen to have secured support for a wife and her children by her deceased husband's paternal clan. Gwako (1998) had earlier wondered if such customary practices were about guaranteeing women's welfare or rather about controlling women's sexuality and limiting their access to property.

5.4 Migration of children

The impact of AIDS has seen a central household and family response being the fragmenting and re-forming of households (Young & Ansell, 2003b). Much of this is around the migration of children from household to household. Indeed, children have always migrated between households within the extended family, often for education reasons (Ansell *et al.*, 2004a), and also because of the wider political-economy in which the household and extended family are situated (Foster, 2000; Madhavan, 2004).

As Madhavan (2004) and Oleke *et al.* (2006) point out however, there has been a shift from one of 'purposive' fostering – for educational reasons for instance – to one

of 'crisis' fostering of children, as the impact of AIDS has become visible. As discussed above, households and the extended family are not collapsing as popular imagery suggests, but are rather evolving and adapting to this. The following section will explore the decision making process and the outcomes of fostering and migration of children, and the broader impacts these responses to AIDS have on children and their carers.

5.4.1 Where should children go?

Decisions about where children should go are generally made without reference to the children concerned. A number of studies identify that this decision is made in a relatively 'rational' manner, based on discussions amongst the remaining family members and being based on an assessment of needs (of the children) and resources (of the receiving family) (Chirwa, 2002). Other studies however, suggest that this relatively rational discussion is actually shaped by other factors. For instance, Verhoef (2005) argues that the relationship between the foster family and those giving the children up for fostering is an important aspect of this decision and can impact on the care the child receives. Abebe *et al.* (2007) argue that simple analyses of resources families have cannot be made only with reference to economic resources, but also includes the ability to provide social care as well.

More recently, there has been growing interest in exploring the role children actively play in deciding where to be placed. A large study looking at migration in Malawi and Lesotho emphasises the agency that children have in decision making. Ansell *et al.* (2004a) suggest that children can choose to exit the household they are placed in, if they are unhappy with the care they are receiving. Some options, which may impact positively or negatively on children's wellbeing, include early marriage and living on the streets or in formal institutions. While recognising the limitations of these options, it moves the children from passive to active actors in their lives. The decision-making role of children is also noted by Chirwa (2002) in his work.

5.4.2 Impact on receiving household

The re-forming of households with new children can place additional burdens on that household. A study in Malawi identified that receiving households' greatest concern was around the financial burden that an additional child (or children) would place on the household (Bandawe & Louw, 1997). The extra work and stress that additional

children cause is also highlighted in the literature (Nyambedha, Wandibba & Aagard-Hansen, 2003; Moore & Henry, 2005). Importantly as Foster (2000) points out, children whose parents have died tend to gather in poorer households, which exacerbates their situation.

Children are not simply burdens on receiving households. Recent work on the role of children in migration has identified two different issues. On the one hand, some children are forced to migrate to earn money for their family. The work of Nyambedha (2004) on the Luo, in western Kenya, identified that children occasionally migrated to urban areas to work as domestic workers. The relationship between the receiving family and the child was one of employer-employee. While this raises questions about the quality of care and life that the child might have in the receiving household, it also highlights the fact that children can play an important role in expanding livelihood strategies for a household (Young *et al.*, 2003b).

Other reasons for child migration can include the provision of care for sick relatives. Ansell *et al.* (2004a; 2004b) highlight that children often migrate to provide care for sick relatives in Malawi and Lesotho. Furthermore, Bray & Brandt (2007) point out that, in South Africa, young children provide much needed care relationships if a person is socially excluded from society because they are living with AIDS. Instead of simply seeing the negative aspects of fostering, there is a growing recognition that migrating children can be productive assets to the household as well.

5.4.3 Impact of migration on children

The impact on children who migrate as a result of AIDS is rapidly becoming an area of concern. It is important to differentiate two separate aspects around the impact of migration on children – first the rupturing of their social relationships from the sending household, and second how the children are incorporated into the receiving household. Around the latter issue, Chirwa (2002) speaks of social inclusion or exclusion of children depending on how they are integrated into the household.

The rupture children experience from their sending household is a cause for concern. Disruption to the children migrating is from a range of issues. Van Blerk & Ansell (2006) highlight that children are removed, due to migration, from friendship groups and the solace these relationships afford them. This is compounded by the complexity of forming new relationships in situations outside of their experience (e.g. shifting

from a rural to an urban household), and by their relatively lack of power within the new household. As children who migrate are split from their parents or other significant adults – as is the case in ambivalent takeover or tug-of-war fostering arrangements - this can also cause problems for the children (Verhoef, 2005; Young *et al.*, 2003b), which can be exacerbated by the situation they are placed in, in the receiving household. However, Bray *et al.* (2007) suggest that this might not be the situation, as many children have already lived in numerous households as part of their daily life and are therefore already used to these ruptures in support.

The view that multiple migrations immunise children against the difficulties associated with adapting to new and sometimes challenging homes seems short-sighted. It downplays the real costs of multiple migrations on individual children, and should be seen as an excuse for not finding long-term child-focused living arrangements. Ansell *et al.* (2004a) ask the question whether child migration is an efficient strategy, particularly where children may have to drop out of school, to change schools, or may be unwelcome in their new households. Some children in rural and urban Lesotho and Malawi migrated five times following parental death (Ansell *et al.*, 2004b), which obviously disrupted their lives. However, this study does not specify the period during which these multiple migrations took place.

Poverty may limit the amount of time and money that can be spent with additional children (Castro *et al.*, 1998). Households, taking in orphaned children out of a sense of obligation, may resent them. Thus, children may not be offered the love, care and support they require after experiencing parental illness and death. The education of children migrating has been one issue that has been focused on, as a proxy for the care and resources that have been allocated to migrating children. Detailed studies of education levels of migrating children emphasise that even when the level of enrolment is similar, the quality of education they receive is often of a lesser standard (Oleke, Blystad, Fylkenes & Tumwine, 2007).

A number of studies have also noted that the gender of a child's deceased parent affects the likelihood of receiving education. Nyamukapa *et al.* (2005) in their work in Zimbabwe suggest that children whose fathers had died were more likely to finish their schooling than those who had lost mothers. Similar outcomes were also seen in Uganda (Aspaas, 1999; Oleke *et al.*, 2007).

At a broader level, the complexity that children face in having to adapt to new households is also a cause for concern. Children are often badly treated, receiving less food, more work and generally poor care, with younger children more at risk (Ansell *et al.*, 2004a; Oleke *et al.*, 2006). Acknowledging that there are differences in the way fostered children are treated by receiving households, Madhavan (2004:1445) suggests that it may be the type and strength of relations between deceased and foster parents which determines how fostered children are treated, rather than kinship per se. A point which is also made by Verhoef (2005).

5.5 Role of women in household responses

There is also an increasing level of interest in who provides care to both people living with HIV and children whose parents have died. The majority of studies internationally highlight that it is women who do this work (Warwick *et al.*, 1998; Cross, 2001). The provision of care by women for those who are ill is often linked into cultural and gendered understandings of care, which place women as caregivers. Work in southern Thailand by Songwathana (2001) and in India by Bharat *et al.* (1999), identifies how these ideas are bound up with social discourses, including religious understandings of women's roles. Bharat *et al.* (1999) argue that while care is provided by women, they are less likely to receive this care themselves if they fall ill and require it.

5.6 Role of men in household responses

Much work on the role of men in households and families in responding to the impact of AIDS, has tended to focus on the role they play in economic provision for the household as workers. In addition, emphasising that they play only a small role in the provision of care to those affected by AIDS.

Recent studies have highlighted that this narrow vision of men may belie the role they play in care giving. Two studies, both from South Africa, suggest that men play a greater role in the provision of care for children than is recognised in many studies. They suggest that changes in the economic structure of South Africa have led to many men being unemployed or under-employed and providing informal and unrecognised care in their communities. While Montgomery, Hosegood, Busza & Timaeus (2006) suggest that this happens within households, Bray *et al.* (2007) argue that this care is a lot more temporary being based within neighbourhoods – possibly reflecting

differences between rural and urban situations respectively. However, both suggest that this narrow focus on females as caregivers appears in academic literature and how people talked about it in the communities they studied, reinforcing gender stereotypes. This is an issue that needs further exploration and understanding.

5.7 Role of elderly in household responses

As households start fragmenting and reforming, there is an emerging focus on the role of grandparents in the provision of care for vulnerable children. Barnett *et al.* (2002) have suggested that the emergence of a pattern of grandparents as primary caregivers for their grandchildren risks 'sundering the inter-generational bond'. In many poorer societies, grandparents assume that they will be cared for by their children, but this social relationship – the inter-generational bond – is now fractured as the middle generation dies and they are expected to care for their grandchildren. As Schatz & Ogunmefun (2007) point out in South Africa, grandparents receiving pensions from the government are often the key breadwinners in extended families. This highlights the shift in demands on the elderly as the AIDS epidemic becomes more pronounced.

Poverty is an underlying theme that structures the experience of elderly caregivers (Abebe *et al.*, 2007). In a study of the provision of care by people over 55 in western Kenya, Nyambedha *et al.* (2003) point out that grandparents decided to provide care through affection for their grandchildren. However, because of their economically weak position, the care they could provide was limited. In one study in Chiang Mai Province in Thailand, grandparents rejoined the workforce to provide for their grandchildren (Safman, 2004). In another study in Lesotho and Malawi, grandparents resumed paid employment in order to ease the difficult transition experienced by children to a new home – i.e. so that they can buy the food children liked (Ansell *et al.*, 2004b). Thus, poverty has knock-on effects on the provision of care for children.

Children in households headed by grandparents also often had worse health and educational outcomes. As Kakooza & Kimuna (2005) highlight in north-west Uganda, few elderly people could afford to place their grandchildren in schools, and this was more pronounced for female than male grandchildren. Elderly people providing care were seen to be stressed, and became more socially isolated as the burden of care increased (Moore *et al.*, 2005). It is important to emphasise that it is elderly women

who carry a major share of the care burden (Nyambedha *et al.*, 2003; Moore *et al.*, 2005; Oleke *et al.*, 2005; Schatz *et al.*, 2007).

Children in the care of grandparents may receive inappropriate care due to caregiver deteriorating emotional and social capacities, and due to diminished household economic capacity (Abebe *et al.*, 2007). Furthermore, children's non-material needs may be overshadowed by the urgency to provide for their basic everyday needs (Ansell *et al.*, 2004b). However, migrations to grandparents' homes, in Lesotho and Malawi, were found to be generally more successful than those to aunts and uncles (Ansell *et al.*, 2004b). Thus, the complexities of child migration and the material and non-material costs borne by receiving households should be acknowledged, and caregivers adequately resourced to provide care and support to migrating children.

5.8 Livelihood responses at the level of households and families

The final household response that will be examined is livelihood responses. Early studies of the household and family responses to the epidemic focused on the impact on livelihoods and strategies of diversification to mitigate the impact.

Households and families have typically responded by shifting patterns of production and consumption and diversifying livelihoods to cope with shifting economic contexts (Ellis, 1998). Many of these studies have focused on households based in rural areas (Barnett *et al.*, 2002), leading to a focus on shifts in forms of agricultural production, with the role of labour loss being central to the patterns of change.

In one of the earliest studies of this, based in rural Rakai, Uganda, Barnett *et al.* (1992) looked at how households responded to illness and death from an agricultural perspective. In responding to illness and death, households tend to reduce the area they cultivate, change the cropping patterns to less labour intensive crops and start to undertake agricultural wage labour. Similar patterns of reduction in cropping and agricultural production are seen in other studies (Appleton, 2000; Hilhorst *et al.*, 2006). Strategies for retaining and replacing labour include hiring additional labour, mobilising labour from the extended family (including migration of children as has been highlighted above), and marrying new spouses (Hilhorst *et al.*, 2006). In addition, studies also document that children are withdrawn from school and that this is more likely to be a girl child than a boy child (Grant *et al.*, 2003).

More recently, studies of livelihood diversification in urban areas have become more prominent and have added depth to rural studies by identifying the relationship between rural and urban livelihood strategies. Cross (2001), focusing on KwaZulu-Natal in South Africa, argues that households diversify in a range of ways. She identifies that even in rural areas the possibilities of agricultural production were highly constrained and informal selling of goods and informal loans were more likely. As Grant *et al.*'s (2003) work on urban Zimbabwe cautions, these diversification strategies were relatively unproductive and threatened to undermine the basis of household production.

Many of these studies of livelihood diversification make the point that it is the context in which they are undertaken that determines how successful they can be in general. Barnett *et al.*'s (1992) work argues that strategies for livelihood diversification encourage social stratification, with richer households undertaking strategies that are successful, while poorer households' responses tend to lead to a downward spiral. The economic and social position of households initially and the economic context that they live in are crucial for understanding the possible range of livelihood diversification strategies and the success that they achieve in undertaking these (Ellis, 1998; Cross, 2001; Grant *et al.*, 2003).

6. Coping

Coping, a concept used in reference to household responses to famines in the 1970s and 1980s, is currently used to explain household responses to the AIDS epidemic (Adams, Cekan & Sauerborn, 1998; Rugalema, 2000; Chase, Wood & Aggleton, 2006). Coping is what families and households do in the face of adversity, and it encompasses attempts by families and households to maintain individual and/or collective survival, security and wellbeing of its members (Adams *et al.*, 1998).

Catalysts (or triggers) of hardship may be generalised - as in the case of widespread poverty, famine, civil wars or household specific - e.g. illness or death of a pivotal household member. Household capacity to deal with poverty, famine, illness or death is influenced by exogenous and endogenous factors (Adams *et al.*, 1998). Some of these factors include societal characteristics, such as religion, culture, patriarchy, caste and hierarchy, pre-existing social networks, and household characteristics, such as socio-economic status, size and composition, and intra-household relations (Bharat *et al.*, 1999; Adams *et al.*, 1998). As no two households are the same, their

responses to a crisis will be different although they may be facing similar difficulties – e.g. prolonged illness of a productive member.

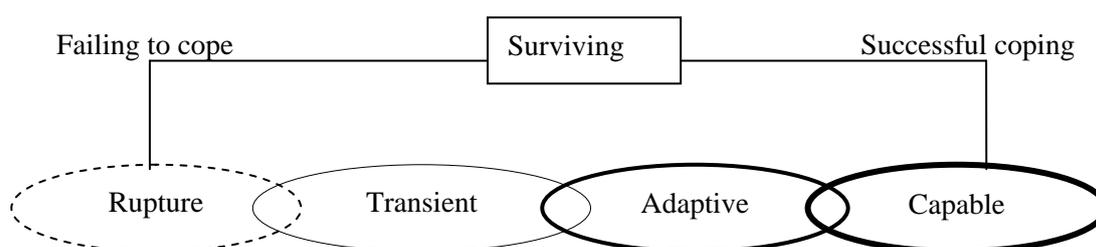
In a society where gender and patriarchy permeate all aspects of life, households may allocate less resources to meeting the needs of women and children than those of men, for example. Furthermore, a well-connected household may call favours from their networks before disposing of household assets. Such coping options make well-connected households more resilient than poorly-connected or conjugal households because they are able to pool more resources without necessarily exacerbating their vulnerability.

6.1 Continuum of household responses

Adams *et al.* (1998) propose that rather than seeing coping as “fixed or generic across households”, coping (and coping strategies, if any) be seen as a continuum – ranging from failure to cope (i.e. household rupture) to successful coping (i.e. a capable household). See Figure 3 below.

Based on their work in urban and rural parts of Ethiopia, Abebe *et al.* (2007:2062) proposed a continuum of household responses to the growing numbers of children requiring care. These are: 1) a *rupturing* household, which is on the verge of dissolution and cannot take in children, 2) a *transient* household, while at risk of collapsing, has access to income or remittances, 3) an *adaptive* household has extended family and/or external agency support, and tends to cope with the situation, and 4) a *capable* household has material and social capacities, and can successfully foster children, if willing to do so. Abebe *et al.* (2007) found that the coping capacity of urban and rural families was different, as access to resources tends to differ by geographic context.

Figure 3: Continuum of household survival (adapted from Abebe *et al.*, 2007)



Along this continuum, households mobilise resources corresponding to the type and level of distress being experienced with some households coping more successfully than others. Successful coping usually depends on family and household resilience, access to resources, and the intensity and duration of the crisis being faced (Adams *et al.*, 1998). It is important to note that a household's fortune may change periodically, placing it at different points along the continuum at different points in time. Also, a household can be bordering between transience and rupture or may be adapting but not necessarily coping successfully. Hence, overlaps between the four coping stages.

Rugalema (2000) and Baylies (2002) rightfully argue that, in resource-constrained settings, the concept of coping may be of limited use. It should be noted here that the choices that families and households make often occur under choice-limited or choice-constrained conditions¹. Coping and coping strategies somehow imply that a household has a planned course of action, when most families and households affected by HIV and AIDS are living from hand to mouth. Rugalema (2000) makes a strong point for a frank discussion of the "real and full costs of coping". For example, selling household assets to meet immediate health care costs may limit household capacity to deal with future adversity.

7. Concluding remarks and recommendations

This review shows that family and household types co-exist, and that they are structured and function differently across space and time. Rather than limiting conceptions of the family to the nuclear family model, it is important that programmes aiming to strengthen families affected by AIDS take cognisance of notions of family (and household) grounded in people's lived experiences. Such notions may ascribe a more collective understanding of family than a conjugal unit, which tends to be the case in the south.

Although evidence on the capacity of the extended family to fulfil its childcare responsibilities is polarised, the extended family remains a critical safety net – particularly, where other services are limited. This review suggests that the extended family system should be viewed realistically, given the dual epidemic of AIDS and poverty. Extended family capacity and childcare arrangements may be constrained by poverty, family dynamics, changing roles and responsibilities with families, and strained kinship relations. It seems economic strengthening of households - through cash transfers - should be primary, as this will ease the financial burden of care.

It should be acknowledged that family environments and childcare arrangements are flexible and fluid, and capable of responding to challenges – albeit unsuccessfully at times. Rather than total collapse or rupture, it is evident that conceptions of family, relatedness and childcare responsibilities are innovatively being reconfigured to include a wider network of kin and social relations.

Although childcare continues to be a collective and shared responsibility within the extended family network, there is evidence of a shift from purposive fostering to crisis fostering. Also, this care tends to be provided by maternal rather than paternal kin as was common practice – which poses difficulties for children in patrilineal societies. While grandparents have always played an important role in child upbringing, it has been shown that some may be ill-equipped – materially and emotionally - for their multiple roles as primary caregivers, home makers and income earners. Furthermore, this may impact negatively on child development and wellbeing. While acknowledging that children's living arrangements may be less than ideal in a context of AIDS and poverty, positive behaviours of support and solidarity - within families and households - need to be acknowledged and encouraged, rather than only focussing on the negative. Instead of singularly focusing on the failings of the extended family system, it should be openly acknowledged that most children continue to be cared for by their extended kin.

The impact of the epidemic on households is mostly seen through the illness and death of productive members, which has devastating consequences for their livelihoods. Roles and responsibilities have to be redefined – with healthy members and women shouldering most of the care burden, and some children assuming adult roles. It is noteworthy that the emotional impact of AIDS on households and children – e.g. uncertainty about the future - tends to be downplayed. More research is required in this area.

This review shows that families and households use various mechanisms to mitigate the burden of the epidemic. However, responses to the epidemic are influenced by a number of contextual factors – e.g. poverty and local constructions of AIDS. Furthermore, it is evident that responses such as transfers and livelihood diversification may favour the better-connected households. The differential impact of the epidemic on households, household differential access to resources, and how

this impacts on the type and timing of responses at the disposal of households should be taken into account in programme development.

Customary practices such as widow inheritance are on the decline and/or being redefined as a result of AIDS, women's empowerment and a range of other factors. It is becoming apparent that while such practices are sometimes promoted as a means of protecting women and children, they may also be used as a means of retaining patriarchal control over family property and over women's sexuality. If customary practices can put women at risk of abuse and/or HIV infection, their gradual disappearance should not be seen as detrimental to the welfare of women and children. In addition, their disappearance should not necessarily be seen as indicative of the collapse of the extended family system, but rather as a sign of the times.

The emergence of children only households has been explained as a phenomenon unique to the AIDS epidemic. However, there does not seem to be sufficient evidence to suggest that this emerging household type is as a result of the AIDS - in South Africa, for example. South Africa's *apartheid* policies and migratory labour patterns dealt a heavy blow to families - splitting and stretching households. As such, some children found themselves on their own for periods of time, in stretched female-headed households and/or being shuttled between kin. From this review, it is apparent that not all orphaned children will have to establish and manage households on their own. Moreover, children only households may be used as a temporary measure, while the extended family is deliberating on who should assume primary responsibility for children requiring care and support. Children only households – notwithstanding their vulnerability - can also be seen as indicative of children's agency and the active role children can play in decision making, as some may have decided to exit unwelcoming households.

While child migration is flagged as a customary African practice and as a viable household survival strategy, in a context of AIDS, the following issues need further attention. That is, the real impact of child migration on individual children, particularly unsuccessful or multiple migrations, and the material and emotional costs – to receiving households - of fostering children affected by AIDS. Sustainable long-term fostering arrangements, based on both kinship and social relations, should be actively encouraged. Considering the double burden of AIDS and poverty, such arrangements will require material, moral and practical support. This support can be

channelled through community initiatives, because they tend to have a better understanding of local realities than external agencies.

Household survival should rather be seen as a continuum, with households falling in and out of adversity at different points in time. Because the AIDS epidemic exacerbates poverty, it should be placed within a broader development context. Therefore, more focus should be placed on improving household survival capacity which would enhance household capacity to meet children's needs.

8. References

- Abebe, T. & Aase, A. (2007). Children, AIDS and the politics of orphan care in Ethiopia: The extended family revisited. *Social Science & Medicine*, 64: 2058-2069.
- Adams, A., Cekan, J. & Sauerborn, R. (1998). Towards a conceptual framework of household coping: reflections from rural West Africa. *Africa*, 68 (2): 263-283.
- Amoateng, A.Y., Richter, L.M., Makiwane, M., & Rama, S. (2004). *Describing the structure and needs of families in South Africa: Towards the development of a national policy framework for families*. A report commissioned by the Department of Social Development. Pretoria: Child Youth and Family Development, Human Sciences Research Council.
- Amoateng, A.Y. & Richter, L. (2003). The state of families in South Africa. In *State of the nation: South Africa 2003-2004*. Daniel, J., Habib, A. & Southall, R. (eds). Cape Town: HSRC Press. 242-267.
- Ansell, N. & van Blerk, L. (2004a). Children's migration as a household / family strategy: Coping with AIDS in Lesotho and Malawi. *Journal of Southern African Studies*, 30 (3): 673-690.
- Ansell, N. & Young, L. (2004b). Enabling households to support successful migration of AIDS orphans in southern Africa. *AIDS Care*, 16 (1): 3-10.
- Aspaas, H.R. (1999). AIDS and orphans in Uganda: Geographical and gender interpretations of household resources. *Social Science Journal*, 36(2): 201-225.
- Appleton, J. (2000). 'At my age I should be sitting under the tree': The impact of AIDS on Tanzanian lakeshore communities. *Gender and Development*, 8 (2):19-27.
- Bandawe, C. & Louw, J. (1997). The experience of family foster care in Malawi: A preliminary investigation. *Child Welfare*, 76 (4): 535-47.
- Barnett, T. & Blaikie, P. (1992). *AIDS in Africa: Its present and future impact*. London: Belhaven Press.

Barnett, T. & Whiteside, A. (2002). Poverty and HIV: Impact, coping and mitigation policy Chapter 8 in *AIDS, public policy and child well-being*. UNICEF Innocenti Research Centre, Florence: Italy.

Bateman, G. (1996). Defining families for policy making. A paper presented at the AIFS Research Conference – Family research: Pathways to policy. Brisbane, 27-29 November.

Baylies, C. (2002). The impact of AIDS in rural households in Africa: A shock like any other? *Development and Change*, 33 (4): 611-632.

Belsey, M. (2008). *The family as the locus of actions to protect and support children*. Paper 5. Joint Learning Initiative on Children and HIV/AIDS.

Belsey, M. (2005). *AIDS and the family: Policy options for a crisis in family capital*. New York: United Nations.

Bharat, S. & Aggleton, P. (1999). Facing the challenge: Household responses to HIV/AIDS in Mumbai, India. *AIDS Care*, 11 (1): 31-44.

Bor, R. & Elford, J. (1994). *The family and HIV*. London: Cassell.

Bray, R. & Brandt, R. (2007). Child care and poverty in South Africa: An ethnographic challenge to conventional interpretations. *Journal of Children and Poverty*, 13 (1): 1-19.

Caldwell, J., Caldwell, P., Ankrah, E.M., Anarfi, J., Agyeman, D., Awusabo-Asare, K. *et al.* (1993). African families and AIDS: Context, reactions and potential interventions. *Health Transition Review*. 3: S1-S14.

Campbell, C., Foulis, C.A., Maimane, S. & Sibiyi, Z. (2005). "I have an evil child at my house": Stigma and HIV/AIDS management in a South African community. *American Journal of Public Health*, 95: 808-815.

Castro, E., Orozco, E., Aggleton, P., Eroza, E. & Hernandez, J. (1998). Family responses to HIV/AIDS in Mexico. *Social Science & Medicine*, 47 (10): 1473-1484.

Chase, E., Wood, K. & Aggleton, P. (2006). Is this 'coping'? Survival strategies of orphans, vulnerable children and young people in Zimbabwe. *Journal of Social Development in Africa*, 21 (1): 85-105.

Cherlin, A. (1983). Changing family and household: Contemporary lessons from historical research. *Annual Review of Sociology*, 9: 51-66.

Chirwa, W. (2002). Social exclusion and inclusion: Challenges to orphan care in Malawi. *Nordic Journal of African Studies*, 11(1): 93-113.

Cooper, D. Harries, J., Myer, L., Orner, P. & Bracken, H. (2007). "Life is still going": Reproductive intentions among HIV-positive women and men in South Africa. *Social Science & Medicine*, 65: 274-283.

Cross, C. (2001). "Sinking deeper down" HIV/AIDS as an economic shock to rural households. *Society in Transition*, 32(1): 133-147.

D'Cruz, P. (2002). Engulfing darkness: the impact of HIV/AIDS on the family. *Families in Society*, 83 (4): 416-430.

Deininger, K., Crommelynck, A. & Kempaka, G. (2005). Impact of AIDS on family composition, welfare, and investment: Evidence from Uganda. *Review of Development Economics*, 9 (3): 303-324.

Drimie, S. (2008). *Families' efforts to secure the future of their children*. Paper 9. Joint Learning Initiative on Children and HIV/AIDS.

Ellis, F. (1998). Household strategies and rural livelihood diversification. *Journal of Development Studies*, 35 (1): 1-38.

Foster, G. (2000). The capacity of the extended family safety net for orphans in Africa. *Psychology, Health and Medicine*, 5 (1): 55-62.

Foster, G. & Williamson, J. (2000). A review of current literature of the impact of HIV/AIDS on children in Sub-Saharan Africa. *AIDS*. 14 (S3): S275-S284.

- Gelles, R.J. (1995). *Contemporary families: A sociological view*. California: Sage Publications, Inc.
- Goode, W.J. (1982). *The family*. Englewood Cliffs: Prentice-Hall, Inc.
- Goody, E.N. (1982). *Parenthood and social reproduction: Fostering and occupational roles in western Africa*. Cambridge: Cambridge University Press.
- Grant, M. & Palmiere, A. (2003). When teas is a luxury: The economic impact of HIV/AIDS in Bulawayo, Zimbabwe. *African Studies*, 62(2): 213-241.
- Guyer, J.I. (1981). Household and community in African studies. *African Studies Review*, 24(2/3): 87-137.
- Gwako, E.L.M. (1998). Widow inheritance among the Maragoli of Western Kenya. *Journal of Anthropological Research*, 54 (2): 173-198.
- Haour-Knipe, M. (2008). *Migration and families affected by HIV/AIDS*. Paper 3. Joint Learning Initiative on Children and HIV/AIDS.
- Henderson, P.C. (2006). South African AIDS orphans: Examining assumptions around vulnerability from the perspective of rural children and youth. *Childhood*, 13(3): 303-327.
- Hilhorst, T., van Liere, M., Ode, A. & de Koning, K. (2006). Impact of AIDS on rural livelihoods in Benue State, Nigeria. *Journal of Social Aspects of HIV/AIDS*, 3 (1): 382-393
- Hosegood, V. (2008). *Demographic evidence of family and household change*. Paper 2. Joint Learning Initiative on Children and HIV/AIDS.
- Hosegood, V., Preston-Whyte, E., Busza, J., Moitse, S & Timaeus, I. (2007). Revealing the full extent of household's experiences of HIV and AIDS in rural South Africa. *Social Science & Medicine*, 65: 1249-1259.
- Hyde, J. (1993). Changing concepts of the family: Responses to HIV/AIDS and development. *Journal of Society for International Development*, 4: 22-24.

Janjaroen, W.S. (1998). The impact of AIDS on household composition and consumption in Thailand. In *Confronting AIDS: Evidence from the developing world*. Brussels: European Commission, 349-354.

Joint United Nations Programme on HIV/AIDS and World Health Organisation. (2006). *AIDS epidemic update: December 2006*. Geneva: UNAIDS and WHO.

Kakooza, J. & Kimuna, S. (2005). HIV/AIDS orphans' education in Uganda: The changing role of older people. *Journal of Intergenerational Relationships*, 3(4): 63-80.

Kayongo-Male, D. & Onyango, P. (1984). *The sociology of the African family*. New York: Longman Inc.

Krishna, V., Bhatti, R., Chandra, P. & Juvva, S. (2005). Unheard voices: Experiences of families living with HIV/AIDS in India. *Contemporary Family Therapy*, 27 (2): 483-506.

Kuo, C.C. (2007). *Dynamic 'families': Caring for children orphaned by AIDS in KwaZulu Natal, South Africa*. Thesis: Master of Philosophy in Development Studies, University of Oxford.

Li, L., Wu, S., Wu, Z., Sun, S., Cui, H. & Jia, M. (2006). Understanding family support for people living with HIV/AIDS in Yunnan, China. *AIDS and Behaviour*, 10 (5): 509-517.

Madhavan, S. (2008). *Families and crises in the developing world*. Paper 1. Joint Learning Initiative on Children and HIV/AIDS.

Madhavan, S. (2004). Fosterage patterns in the age of AIDS: continuity and change. *Social Science & Medicine*, 58: 1443-1454.

McGrath, J., Ankrah, E. & Maxine. (1993). AIDS and the urban family: Its impact in Kampala, Uganda. *AIDS Care*, 5(1).

- Meintjes, H. & Giese, S. (2006). Spinning the epidemic: The making of mythologies of orphanhood in the context of AIDS. *Childhood*, 13 (3): 407-430.
- Montgomery, C., Hosegood, V., Busza, J. & Timaeus, I. (2006). Men's involvement in the South African family: Engendering change in the era of AIDS. *Social Science & Medicine*, 62: 2411-2419.
- Moore, A. & Henry, D. (2005). Experiences of older informal caregivers to people with HIV/AIDS in Lome, Togo. *Ageing International*, 30(2): 147-166.
- Mturi, A.K., Xaba, T. & Sekokotla, D. (2005). *Assessment of circumstances facing contemporary families in South Africa*. Durban, South Africa: School of Development Studies, University of KwaZulu Natal.
- Murphy, L., Harvey, P. & Silvestre, E. (2005). How do we know what we know about the impact of AIDS on food and livelihood insecurity? A review of empirical research from rural sub Saharan Africa. *Human Organization*, 64 (3): 265-275.
- Nkurunziza, E. & Rakodi, C. (2005). *Urban families under pressure: Conceptual and methodological issues in the study of poverty, HIV/AIDS and livelihood strategies*. Urban household livelihoods and HIV/AIDS – Working Paper No. 1, University of Birmingham, International Development Department.
- Ntozi, J.P.M. (1997). Effects of AIDS on children: The problem of orphans in Uganda. *Health Transition Review*, Supplement to Volume 7: 125-144.
- Ntozi, J.M. & Zirimenya S. (1999). Changes in household composition and family structure during the AIDS epidemic in Uganda. *The Continuing African AIDS Epidemic*, 193-209.
- Nyambedha, E.O. (2004). Change and continuity in kin-based support systems for widows and orphans among the Luo in western Kenya. *African Sociological Review*, 8 (1): 139-153.
- Nyambedha, E., Wandibba, S. & Aagard-Hansen, J. (2003). 'Retirement lost' – The new role of the elderly as caretakers for orphans in western Kenya. *Journal of Cross Cultural Gerontology*, 18: 33-52.

Nyambedha, E., Wandibba, S. & Aagaard-Hansen, J. (2001). Policy implications of the inadequate support systems for orphans in Western Kenya. *Health Policy*, 58(1): 83-96.

Nyamukapa, C. & Gregson, S. (2005). Extended family's and women's roles in safeguarding orphans' education in AIDS-Afflicted rural Zimbabwe. *Social Science & Medicine*, 60(10): 2155-2167.

Oleke, C., Blystad, A. & Rekdal, O. (2005). 'When the obvious brother is not there': Political and cultural contexts of the orphan challenge in northern Uganda. *Social Science & Medicine*, 61: 2628-2638.

Oleke, C., Blystad, A., Fylkenes, K. & Tumwine, J. (2007). Constraints to education opportunities of orphans: A community-based study from northern Uganda. *AIDS Care*, 19(3): 361-368.

Oleke, C., Blystad, A., Moland, K.M., Rekdal, O.B & Heggenhougen, K. (2006). The varying vulnerability of African orphans: The case of the Langi, northern Uganda. *Childhood*, 13(2): 267-284.

Parsons, T. (1979). *The social system*. London: Routledge & Kegan Paul Ltd.

Preston-Whyte, E. (1978). Families without marriage: A Zulu case study. In Argyle and Preston-Whyte (eds.), *Social System and Tradition in Southern Africa*. Oxford University Press. 55-83.

Radcliffe-Brown, A.R. & Forde, D. (1950). *African systems of kinship and marriage*. London: Oxford University Press.

Richter, L. (2002). Envisaging a research, policy and advocacy agenda: Setting the scene. Discussion on *Globalisation, regional integration, governance, and household viability*. Ford Foundation Southern Africa Office, Johannesburg, 31st May 2002.

Richter, L., Manegold, J., Pather, R. (2004). *Family and community interventions for children affected by AIDS*. Social Aspects of HIV/AIDS and Health Research Programme, Human Sciences Research Council.

Roby, J. & Eddleman, N. (2007). When she is gone: Child care plans of Mozambican mothers with terminal illnesses. *Families in Society*, 88(2): 292-301.

Rugalema, G. (2000). Coping or struggling? A journey into the impact of HIV/AIDS in southern Africa. *Review of African Political Economy*, 27(86): 537-545.

Russell, M. (2004). *Understanding black households in southern Africa: The African kinship and western nuclear family systems*. Centre for Social Science Research, University of Cape Town. CSSR Working Paper No. 67.

Safman, R. (2004). Assessing the impact of orphanhood on Thai children affected by AIDS and their caregivers. *AIDS Care*, 16(1): 11-19.

Sauerborn, R., Adams, A. & Hien, M. (1996). Household strategies to cope with the economic costs of illness. *Social Science and Medicine*. 43(3): 291-301.

Schatz, E. & Ogunmefun, C. (2007). Caring and contributing: The role of older women in rural South African multi-generational households in the HIV/AIDS era. *World Development*, 35(8): 1390-1403.

Segalen, M. (1986). *Historical anthropology of the family*. Cambridge: Cambridge University Press.

Sekokotla, D. & Mturi, A.J. (2004). Effects of HIV/AIDS on the South African families. *Loyola Journal of Social Sciences*, 18 (1): 189-211.

Singhanetra-Renard, A., Chongsatitmun, C. & Aggleton, P. (2001). Care and support for people living with HIV/AIDS in northern Thailand: Findings from an in-depth qualitative study. *Culture, Health and Sexuality*, 3(2): 167-182.

Songwathana, P. (2001). Women and AIDS caregiving: Women's work? *Health care for Women International*, 22: 263-279.

- UNAIDS. (2007). *AIDS Epidemic Update – 2007*. Geneva: UNAIDS.
- UNICEF. (2008). *Children and AIDS: Second stocktaking report*. New York: UNICEF.
- Van Blerk, L. & Ansell, N. (2007). Alternative care giving in the context of AIDS in southern Africa: Complex strategies for care. *Journal of International Development*, 19 (7): 865-884.
- Van Blerk, L. & Ansell, N. (2006). Children's experiences of migration: Moving in the wake of AIDS in southern Africa. *Environment and Planning D: Society and Space*, 24: 449-471.
- Verhoef, H. (2005). 'A child has many mothers': Views of child fostering in northwestern Cameroon. *Childhood*, 12 (3): 369-390.
- Warwick, L., Bharat, S., Castro, R., García, R., Leshabari, M., Singhanetra-Renard, A. & Aggleton, P. (1998). Household and community responses to HIV and AIDS in developing countries. *Critical Public Health*, 8 (4): 311-328.
- Wilk, R.R. & Netting, R.M. (1984). Households: Changing forms and functions. In: *Households: Comparative and historical studies of the domestic group*. Netting, R.M., Wilk, R.R. & Arnould E.J. (eds). California: University of California Press.
- Yanagisako, S.J. (1979). Family and household: Analysis of domestic groups. *Annual Review of Anthropology*, 8: 161-205.
- Young, L. & Ansell, N. (2003a). Fluid households, complex families: The impacts of children's migration as a response to HIV/AIDS in Southern Africa. *The Professional Geographer*, 55 (4): 464-476.
- Young, L., & Ansell, N. (2003b). Young AIDS migrants in Southern Africa: Policy implications for empowering children. *AIDS Care*, 15 (3): 337-345.

Appendix 1: Glossary of terms

Extended family – a domestic group made up of a number of households

Family – a group of people connected by blood, marriage or adoption

Household – a set of individuals who share living space, cook and eat together, contribute to day-to-day running of domestic group

Kinship – relationships which can be traced through one or more parent-child or marriage linkages

Line of descent or lineage – an arrangement of relatives of an individual

Neolocality – a couple is expected to establish their own independent household

Nuclear family – parents and their offspring

Patrilocality – a newly married couple is expected to set up residence in the groom's father's household.

ⁱ Joint Learning Initiative on Children and HIV/AIDS. Learning group 1 – Strengthening families: Meeting notes. First Meeting of the Joint Learning Initiative on Children and HIV/AIDS. Tala Game Reserve, Durban, March 7th and 8th 2007.