CHAPTER TWO

Who cares?

The changing role of African extended families

2. Who cares?
The changing role of African extended families

2.1 Introduction

2.2 Traditional role of African families: an anthropological perspective

2.2.1 Family as an informal social security provider

2.2.2 Foster care by relatives

2.3 Changes in the family structure

2.3.1 Labour migration

2.3.2 Urbanisation

2.3.3 The HIV epidemic

- **(i) Overview of the impact**
- **(ii) Impact on families and family structure**
- **(iii) Children in times of AIDS**
- **(iv) Coping by providing 'good enough care'?**

2.4 Conclusion

2.1 Introduction

In many societies, extended families perform various important functions. Often, the extended family network is the first line of defence in times of misfortune. It is a source of financial, emotional and physical security against various difficulties. The strong family network system or kinship network is not only common to African societies, but has also played a role in other societies in Asia, Latin America and Europe.[1] Although it is important not to overemphasise or romanticise the role played by the extended family network system,[2] there is no denying that, in Africa, the extended family network is one of the main coping mechanisms where there is a lack of an institutionalised social security system.[3]

Traditionally, in Africa, family provided the most reliable social security to its vulnerable members, such as the poor, children and elderly.[4] The traditional care system was built in complex family systems which ensured the reciprocal care and assistance among generations.[5] Partly due to the tradition of informal foster care by extended families, governments in Africa have been slow at intervening in care

---

1 R Dirks, 'Social responses during severe food shortages and famine' (1980) 21/1 *Current anthropology* 25, Robert Dirks explains how kinship and friendship network played an extremely important role during the famine in Western Netherlands in 1944-1945; R M Safman, 'Assessing the impact of orphanhood on Thai children affected by AIDS and their caregivers' (2004) 16/1 *AIDS Care* 11-19, R M Safman examines the coping strategy of Thai families and observes that "intra-familiar fostering arrangement may prove even more central in Thailand than they are in Africa." He bases his argument on the fact that in Thailand, child-headed households, which are seen as an important extended family coping strategy, are viewed less favourably.

2 J Iliffe, *The African poor: a history*, Cambridge University Press (1987) 7.

3 J Iliffe, 1987 (as above) 7, Iliffe identified four means of survival in Asia and Europe; institutions established by the society as a whole, informal and individual charity, the poor initiated organisations and their own efforts. He further suggested, however, that the scarcity of such institutions resulted Africans' hostility towards institutional care for the poor.; see also A Adepoju & W Mbugua, 'The African family: an overview of changing forms' in A Adepoju (ed) *Family, population and development in Africa*, Zed Books (1997) 43; J Goody, 'Futures of the family in rural Africa' (1989) 15 *Population and Development Review: supplement - Rural Development and Population: Institutions and Policy* 119-144.

4 N A Apt, 'Ageing and the changing role of the family and the communities: an African perspective' (2002) 55 *International Social Security Review* 39.

5 N A Apt, 2002 (as above) 39.

practices of children who are orphaned, abandoned, or abused in a family setting.[6] Such tradition minimised the necessity of government intervention.

However, as society changes, the role and structure of the extended families have also changed. Due to poverty, urbanisation, migration, the development of a cash economy, westernisation and labour movements, the kinship network system has been undergoing thorough restructuring and reorganisation.[7] It is true that extended families are still the major provider of social safety nets in various African societies.[8] Nevertheless, there has been an over-reliance on the kinship network system, and the HIV epidemic might serve as a last blow to already overstretched extended family resources.[9] Without a speedy and adequate government intervention, traditional 'orphan care', which relied almost exclusively on extended families, will not be able to sustain itself.[10]

The chapter explores the changing role and capacity of the kinship network system in African societies and the consequent need for alternative methods of care for children who are deprived of their parental care. The chapter examines the factors leading to the change in traditional kinship relationship and provides a brief overview of the impact of the HIV epidemic on the workings of the traditional family network system. Despite the important role played by the extended family network in Africa, many anthropologists argue that, in Africa, there is no equivalent term to the Western notion of family.[11] The family is a much more inclusive notion in the African usage than in

---

6 *Children at the Centre: a guide to supporting community groups caring for vulnerable children*, Save the Children UK (2007) 1.

7 G Foster, 'The capacity of the extended family safety net for orphans in Africa' (2000) 5/1 *Psychology, Health and Medicine* 56.

8 See A Adepoju & W Mbugua, 1997 (n 3 above); A B C Ocholla-Ayayo, 'African family between tradition and modernity' in A Adepoju (ed) *Family, population and development in Africa*, Zed Books (1997).

9 See C Cross, 'Sinking deeper down: HIV/AIDS as an economic shock to rural households' in (2001) 32/1 *Society in Transition* 133-145; C Baylies, 'The impact of AIDS on rural households in Africa: a shock like any other?' (2002) 33/4 *Development and Change* 611.

10 S Tsegaye, *HIV/AIDS, orphans and child-headed households in sub-Saharan Africa*, African Child Policy Forum (2008) 16.

11 D W Sabean, 'The history of the family in Africa and Europe: some comparative perspectives' (1983) 24/2 *The Journal of African History* 164.

Euro-American usage.[12] Marks and Rathbone partly attribute the lack of studies on African family history to the problem of definition and argue that in pre-modern Africa, the term 'family' itself was problematic.[13] To understand the African notion of family, one must ask three pertinent questions:[14] How was 'family' understood in the African context? What were its functions? What is it changing into?

Following the introductory section, section 2.2 examines the traditional role of the extended family network in various traditional African societies based on anthropological studies on kinship relationships. Section 2.3 examines myriad factors that affect the functions of the traditional extended family network system in modern African societies such as urbanisation, labour migration and the HIV epidemic. Although the section is not expressly divided into pre- and post-AIDS African societies, giving separate consideration is important, as the epidemic has an unprecedented impact on every section of African societies. The section shows how the epidemic affected and changed the African social fabric and created the need for a stronger and different type of governmental intervention in matters relating to the care of children, among others. It is true that the extent of such resilience is different from society to society. For instance, in rural communities, the respect for an extended family network is better preserved compared to more urbanised communities.[15] In many communities, the extended family network continues to be the major social security provider to a large extent. However, as illustrated in the section, the extended family network that once epitomised African family life is changing in the face of strings of modern challenges. Section 2.4 is the concluding section of the chapter.

---

12 A B C Ocholla-Ayayo, 1997 (n 8 above) 60.

13 S Marks & R Rathbone, 'The history of the family in Africa: introduction' (1983) 24/2 *The Journal of African History* 149; Also see M Vaughan, 'Which family?: problem in the reconstruction of the history of the family as an economic and cultural unit' (1983) 24/2 *The Journal of African History* 276, Vaughan attributes the scarcity of direct historical sources for the history of family in most part of Africa and for most part of African history directly to the problem of 'family' as a unit of analysis. She argues that 'family' is a too ill-defined concept for the study of the family.

14 A Armstrong, 'Law and the family in Southern Africa' in A Adepoju (ed) *Family, population, and development in Africa,* Zed Books (1997) 187.

15 G Foster, 'Safety nets for children affected by HIV/AIDS in Southern Africa', R Pharoah (ed) *A generation at risk? HIV/AIDS, vulnerable children and security in Southern Africa,* Institute for Security Studies, Monograph Series No 109 (December 2004).

2.2 From the traditional to modern African family: an anthropological perspective

2.2.1 Family as an informal social security provider

John Roscoe proclaimed in his study of the Baganda:[16]

> Real poverty did not exist. When a member of a clan wished to buy a wife, it was the duty of all the other members to help him to do so; when a person got into debt, the clan combined to assist him to pay it, or if a clansman was fined, the clan helped to pay the fine. There were no orphans, because all the father's brothers were fathers to a child; and the heir to a deceased person immediately adopted and became responsible for the children of the latter.

This utopian vision of the Bagandan society might not be applicable to all other African societies. Different cultures and tribes had their own particular weakness and cruelty; their own particular categories of unsupported and abandoned poor based on taboos and superstitions.[17] In the same way that it would be misleading to talk about 'Africans' as a homogenous group, it is misleading to talk about the homogenous 'African family'[18] or 'African family tradition' as an absolute point of reference. For example, despite the importance of kinship relations and extended family life in most part of Africa, it was common for Amhara to leave their parents upon their marriage and form a new household.[19] The extended family had little significance and poor Amhara had little support from kinsmen.[20] Nonetheless, African families in general provided, and still continue to provide, an important social security to family members in difficulties and the extended family network system continues to perform

---

16 J Roscoe, *The Baganda, an account of their native customs and beliefs* (Frank Cass & Co., 1965) 12.

17 J Iliffe, 1987 (n 2 above) 7, 59 & 70; Each society has its own categories of people who had no support from extended families. It could be orphans in one society, childless elderly in another or barren women. Further it was noted that victims of epilepsy and especially leprosy sufferers were excluded from the society with unusual cruelty. O N Gakuru *et al.*, 'Children in debt: the experience of street children in Nairobi', J L P Lugalla & C G Kibassa (eds) *Poverty, AIDS, and street children in East Africa*, Edwin Mellen Press (2002) 27-28.

18 A Adepoju, 'Introduction' in A Adepoju (ed) *Family, population and development in Africa*, Zed Books (1997) 8.

19 J Iliffe, 1987 (n 2 above) 15 & 16.

20 As above, 15 & 16. The author notes the uncommonly weak family solidarity as a main reason for little family support for the poor.

the role of safety net.[21] The traditional households also played a role of distribution and redistribution of food and other goods among members to ensure that every member was taken care of and benefited from the product of communal labour.[22]

The role of the extended family as a social security provider is more pronounced in countries with weak public social security mechanisms.[23] Although the semi-institutionalised charity or self-help organisations also existed in Africa, the institutionalised social security system was, and still is, weak if not non-existent in the majority of African states.[24] Therefore, traditional social security measures, which consist of mutual assistance within the family, clan and tribes, played a vital role in assisting needy members of the community.[25] The extended families continue to play an important role as an informal social security provider. A study by the World Bank found that in Tanzania, AIDS affected households were mainly supported by relatives and community groups such as savings clubs or burial societies and only roughly around 10 per cent of their needs were met by NGOs and other agencies.[26] In Kenya, 41 per cent of total HIV-related expenditure came directly from Kenyan citizens on an individual basis; in Rwanda, 93 per cent of HIV-related spending was out-of-pocket spending by private citizens;[27] in the Kisesa community of Northwest Tanzania, 93 per cent of children who are orphaned were supported by extended family members.[28] Furthermore, a study by Save the Children claims that 'out-of-pocket spending by

---

21 J Iliffe, 1987 (n 2 above) 7.

22 O N Gakuru *et al.*, 2002 (n 17 above).

23 Z Zimmer & J Dayton 'Older adults in sub-Saharan Africa living with children and grandchildren' (2005) 59/3 *Population Studies* 296.

24 J Iliffe, 1987 (n 2 above) 7; also see D Ghai, 'Social security priorities and patterns: a global perspective', Education and outreach programme Discussion paper DP/141/2002, International Institute for Labour Studies, 13, available at: http://www.ilo.org/public/english/bureau/inst/download/dp14102.pdf [accessed: 7 July 2007].

25 D Kayongo-Male & P Onyango, *The sociology of the African family*, Longman (1984) 81; J Iliffe, 1987 (n 2 above) 7; A B C Ocholla-Ayayo, 1997 (n 8 above) 71.

26 G Mutangadura, D Mukurazita & H Jackson, 'A review of household and community responses to the HIV epidemic in the rural areas of sub-Saharan Africa', UNAIDS Best practice collection, Geneva, cited in G Foster, 'Under the radar - Community safety nets for children affected by HIV/AIDS in poor households in sub-Saharan Africa', UNRISD/ Training and Research Support Centre (January 2005); also cited in G Foster, 'Children who live in communities affected by AIDS' (2006) 367 *Lancet* 701.

27 G Foster, 2005 (as above) 15.

28 E O Nyambedha *et al.*, 'Policy implications of the inadequate support systems for orphans in Western Kenya' (2001) 58 *Health Policy* 93.

households … is the largest single component of overall HIV and AIDS expenditure in African countries.'[29] These examples clearly reflect the realities of many African states: a weak social security and health care system, and a compensatory role of extended family.

Formal social security can be broadly defined as governmental programmes or measures that aim to provide economic assistance to people who are financially vulnerable due to old age, disability or other dependency.[30] In the simplest terms, the main objective of most social security provisions is to ensure access to health care and basic income security.[31] The institutionalised social security system is difficult to achieve in Africa, mainly due to the lack of resource and appropriate infrastructure. In many states, the majority of people are employed in the informal sector with low wages. In low-income developing countries, nearly 85 per cent of the work force is employed outside of the formal sector.[32] For instance, in Malawi, an estimated 84 per cent of the population lives in rural areas and the majority of them are engaged in subsistence farming.[33] Moreover, over half of its population is living in extreme poverty.[34] In countries such as Malawi, where the majority of the population is extremely poor and lives off the land by subsistence farming, a conventional social security system, which relies on the contribution from the formal sector of economy, is difficult to sustain. Income-related taxes are difficult to impose when the majority

---

29 G Foster, *Bottlenecks and drip-feeds: channelling resources to communities responding to orphans and vulnerable children in southern Africa*, Save the Children (2005) 1; G Foster, 2006 (n 26 above).

30 See D Kayongo-Male & P Onyango, 1984 (n 25 above) 80.

31 *Social security: a new consensus*, ILO: Geneva (2001) 38; A Tostensen, 'Towards feasible social security systems in sub-Saharan Africa' (2004) 5 *Chr. Michelsen Institute Development Studies and Human Rights Working Paper*, available at: www.cmi.no/publications [accessed: 10 July 2007] Tostensen states, 'amelioration, prevention and development' as the main aim of the social assistance programmes. See Tostensen, 2004, 3.

32 WIEGO Programme Areas: social protection, cited in A H Dekker, 'The role of informal social security in an inter-generational society', paper submitted for International Social Security Association 4th International Research Conference on Social Security, *Social security in a long life society*, Antwerp, Belgium (5-7 May 2003).

33 Statistics from United Nations International Strategy for the Disaster Reduction, available at: http://www.unisdr.org/eng/country-inform/malawi-general.htm [accessed: 17 December 2009].

34 According to the UNDP HRD 2004, 76.1 % of the population lives below $2 a day and 65.3 % lives below the national poverty line in Malawi.

of the population does not have a sufficient and regular income.[35] Therefore, governments often do not have a regular source of income to develop a reliable social security infrastructure.[36]

Furthermore, public social security programmes often fail to reach the people who are in the most vulnerable position. In South Africa, there are three grants that are available for children: child support grant; care dependency grant and foster child grant.[37] South Africa has one of the most comprehensive social assistance programmes in Southern Africa.[38] In 2009, the Department of Social Development reported that as of April 2009, 8.8 million children were receiving child support grant.[39] As of 1 January 2010, the chid support grant is expanded to cover children who were born on or after 1 October 1994.[40] In general, to access such grants, the applicants are required to provide documents such as the Identity Book (ID) of the applicant, the child's ID, or a birth certificate and proof of income.[41] In addition to that, to apply for a foster child grant, the applicant is required to provide a court order allowing the applicant to foster from the Children's Court. For a care dependency grant, the applicant is required to submit a medical report of the child from a medical officer.[42] Where the basic documents are lacking, other documents, such as a sworn statement on a form provided by the South African Social Service Agency and, where available, the proof that formal identification documents have been applied for at the Home Affairs.[43] Such documents could be supported by a sworn statement by a

---

35 A Maes, 'Informal economic and social security in sub-Saharan Africa' (2003) 56/3-4 *International Social Security Review* 43; A Tostensen, 2004 (n 31 above) 7.

36 A Maes, 2003 (as above) 43.

37 Social Assistance Act No 13 of 2004.

38 E Kaseke, 'The role of social security in South Africa' (2010) 53 *International Social Work* 160.

39 S Pendlebury *et al.*, *South African Child Gauge 2008/2009*, Children's Institute, University of Cape Town (2009) 14.

40 South Africa Government Gazette, No 32853 (31 December 2009).

41 J Sloth-Nielsen, *Realising the rights of children growing up in child-headed households: a guide to laws, policies and social advocacy*, Community Law Centre, University of Western Cape (2004) 27-28.

42 J Sloth-Nielsen, 2004 (as above) 27-28.

43 *Reference Guide to Paralegals*, Black Sash (February 2010) 35. However, the grants will be discontinued if the applicants do not apply for the formal documents within three-month period or fail to return the proof of the application to the SASSA within the three-month time frame. In *Alliance for Children's Entitlement to Social Security v Minister for Social Development*, the

reputable person who knows the applicant, and other documents such as baptismal certificate, school reports or clinic cards.[44] However, obtaining such documents can be challenging as people are unaware of the format and information required to put in the statement or affidavit to assess the grants.[45]

Also, in-kind programmes targeting children, such as school feeding programmes, although important, can hardly be universal, as they may not reach the most vulnerable children who are forced out of school.[46] The development of an informal social security system, whether kinship-based or community-based, is, therefore, an adaptive mechanism of poor people who are excluded from the formal social security system.[47] The existence of a strong kinship networks may not be unique in Africa, but in the absence of a formal institutionalised social security system, the kinship network system is proving to be vital in various African societies, both traditional and modern.[48] The importance of the extended family network system against the economic and social hardships is also illustrated in language. In several African languages, the word for 'poor' suggests a lack of kin and friends.[49] Although the existence of a weak family tie is unlikely to be the only cause of the extreme poverty,

---

High Court held that the lack of basic documents should not prevent children from assessing grants. See S Pendlebury *et al.*, 2009 (n 39 above) 14.

44 Black Sash, 2010 (as above).

45 For further information on the required documents, see http://www.services.gov.za/ServicesForPeople/Socialbenefits/socialservices/childsupportgrant.aspx?Language=en-ZA [accessed: 29 July 2009].

46 M Grosh, 'Weaving the social safety net', Presentation at conference: *Protecting the vulnerable: the design and implementation of effective safety nets*, (December 2-13, 2002) The World Bank, Washington DC, slide 41; also cited in G Foster, 2005 (n 26 above).

47 A H Dekker, 2003 (n 32 above) 8.

48 J Aldous, 'Urbanisation, the extended family, and kinship ties in West Africa' (1962) 41/1 *Social Force* 11. Although it is observed that due to urbanisation and weakening of the kinship ties, the assistance obligation to relatives has lessened, still the extended family network system substitutes for a 'non-existent public welfare programme.' A Maes, 2003 (n 35 above) 45 & 55 The most reliable source of informal social security is the 'household-based system' which is based on the strong family ties in Africa.; A B C Ocholla-Ayayo, 1997 (n 8 above). Ocholla-Ayayo suggests that despite existence of limited government-supported social security schemes, people preferred to depend on the members of kinship group. Various interrelated factors that may explain it include the difficulty of accessing those formal social security measures and slow and unreliable service delivery.

49 J Iliffe, 1987 (n 2 above) 7; J Vansina, *The Tio Kingdom of the middle Congo 1880-1892*, London (1973) 306. Vansina's study on the Tio kingdom in Congo shows that poverty is understood as 'not having many kinsmen, being alone and powerless.'

the identification of poverty with a lack of family support was common in the twentieth-century Africa.[50]

The importance of the extended family network as a social security system is illustrated in the vast amount of anthropological work on African tribes. For instance, in the Kavirondo culture in west Kenya, the close clan organisation based on the genealogical relationship made sure that no individual became socially or economically destitute.[51] The close kinship relationship is further illustrated by the usage of the kinship terminology, such as father, mother, brother and sister. The terms are used much widely; the term *baba wange* (my father) is used to address all the married men of the speaker's clan who belong to the generation of his natural father.[52]

The extension of the kinship terminology beyond the immediate family does not necessarily mean that there was no distinction between the immediate family and other members in the lineage.[53] Nevertheless, it implies the close kinship relationship, especially during the crisis. As shown in Bantu culture, if one's father dies, one of the nearest kin stepped in automatically;[54] hence orphanhood, widowhood and other hardships, despite their personal nature, were dealt with collectively and were not faced alone.[55] Similar cultural practices can also be found in the Shona people in

---

50 J Iliffe, 1987 (n 2 above) 53.

51 G Wagner, *The Bantu of Western Kenya: with special reference to the Vugusu and Logoli vol I* , Oxford University Press (1970) 73; It is also observed that the Xhosa showed a high level of reciprocity and mutual aid that worked as a self-regulated welfare system. See J Iliffe, 1987 (n 2 above) 70-72.

52 G Wagner, 1970 (as above) 72.

53 M F C Bourdillon, *The Shona peoples: an ethnography of the contemporary Shona, with special reference to their religion*, Mambo Press (1976) 44.

54 G Wagner, 1970 (n 51 above) 72; J C Caldwell & P Caldwell, while trying to explain why fertility rate is high in Africa, states that culturally differential treatment between children was seen as 'an offence against the lineage and against the children's grandparents'. Although such assertion is a generalisation, it illustrates strong family ties based on a sense of obligation. See Caldwell & Caldwell, 'Is the Asian family planning program model suited to Africa' (1988) 19/1 *Studies in Family Planning* 24

55 J Goody, 1989 (n 3 above) 122; I Schapera 'The old Bantu culture' in I Schapera (ed) *Western civilization and the natives of South Africa: studies in culture contact*, London (1935) 15-16 Schapera also notes the similar findings in South Africa. Kinship members were obliged to assist each other in most of the major domestic tasks and economic activities; It was further noted that among the Xhosa, destitute children were rare as orphaned children were taken care of by the father's brother. See H Lichtenstein cited in J Iliffe, 1987 (n 2 above) 72; O N Gakuru *et al*., (n 17 above) 26.

Zimbabwe.[56] The kinship terms were extended beyond immediate family and upon the death of a father, the next of kin assumed the legal and economic responsibilities.[57] Abebe and Aase's study of the Ethiopian extended family system distinguishes between two patterns of extended family structures; blood-related extended families and 'fictive kinships'.[58] Fictive kinships indicate people, who despite having no blood relations, have deliberately created social ties based on common ground, such as religion, gender or social status, to assist each other. Religious-based brotherhood or sisterhood are the examples of 'fictive' kinship networks. The example above demonstrates that the concept of extended family in some African societies may not be restricted only to blood ties.

2.2.2 Foster care by relatives

Another important characteristic of the African family life is the frequency of foster care arrangements.[59] For example, in Gonja, a kingdom in northern Ghana, foster care was frequent and often considered to have a positive influence on children's socialisation.[60] Although in some cases, foster parents asked for a specific child to foster, in the majority of the cases, children were from homes broken either by the death of parents or parents' divorce.[61]

---

56 M F C Bourdillon, *Where are the ancestors? Changing culture in Zimbabwe*, Harare: University of Zimbabwe (1999) cited in C Nyamukapa & S Gregson, 'Extended family's and women's roles in safeguarding orphans' education in AIDS-affected rural Zimbabwe' (2005) 60 *Social Science & Medicine* 2158.

57 M F C Bourdillon, 1976 (n 53 above) 43.

58 T Abebe & A Aase, 'Children, AIDS and the politics of orphan care in Ethiopia: The extended family revisited' (2007) 64 *Social Science & Medicine* 2059.

59 D Kayongo-Male & P Onyango, 1984 (n 25 above) 6 & 19. Although the tradition of fosterage is common in many African states, foster care in a formal and legal sense is not common in Africa. The same goes for adoption. Informal adoption by the extended family is a common tradition. Adoption in a formal sense is not a common practice in the most parts of Africa. See *Caring for children affected by HIV and AIDS*, UNICEF-Innocenti Research Centre (IRC) (November 2006) 18.

60 P Mayer, *Socialisation: The approach from social anthropology*, Tavistock publications (1970) 52.

61 P Mayer, 1970 (as above) 58

The tradition of foster care arrangements was used to provide for children in crisis[62] and also to reemphasise kin solidarity. Even today, fostering serves certain economic functions. Research done in Burkina Faso illustrates that child fostering is often used as a 'risk coping mechanism'.[63] For instance, households that experience economic difficulties or suffer from particularly severe economic shocks are more likely to send children to be fostered. In turn, households that are perceived to be able to provide better educational or job opportunities are more likely to receive children. Fostering can be also due to the marital status of the parents. When a mother is young or unmarried, the child is more likely to be fostered by grandparents.[64] Children are also likely to be fostered when parents are divorced or a divorced person is remarried.[65] The extended families are more likely to take on a role of fostering rather than risk the child being mistreated by unrelated step-parents.[66]

The tradition of fostering still persists in various parts of Africa.[67] In the late 1990s, Page showed, using the data from the World Fertility Survey and the Demographic and Health Survey, that 21 per cent of under 15 year-old children in Lesotho were not living with their parents; in Côte d'Ivoire, 21 to 22 per cent of children were fostered by relatives; 13 to 28 per cent in Ghana; 14 to 24 per cent in Cameroon; nine to 17 per cent in Kenya; and nine to 14 per cent in Nigeria.[68] While the reasons for fostering in those countries were not investigated, the data indicate several factors. First of all, the high incidence of fostering may mean that the strong extended family network still exists, and it is reinforced through fostering practices. For instance, in Lesotho it was a common practice for the eldest child to live with his or her maternal grandparents

62 A Shorter, *The East African Societies*, Routledge & Kegan Paul (1974) 76.

63 R Akresh, 'Risk, Network Quality and Family Structure: Child Fostering Decisions in Burkina Faso' (January, 2005) IZA Discussion Paper No 1471: Yale University Economic Growth Centre Discussion Paper No 922, available at: http://ssrn.com/abstract=643163 [accessed: 23 April 2007] 2 & 20.

64 J C Caldwell, 'The impact of the African HIV epidemic' (1997) 7/2 *Health Transition Review* 178.

65 J C Caldwell, 1997 (as above) 178.

66 As above 178.

67 See K Deininger *et al.*, 'AIDS-induced orphans as systemic shock: magnitude, impact and programmic interventions in Africa' (2003) 31/7 *World Development* 1213.

68 H Page, 'Childrearing versus childbearing: co-residence of mother and child in sub-Saharan Africa', in R J Lesthaeghe (ed) *Reproduction and social organisation in sub-Saharan Africa*, Berkeley: University of California Press (1998) 401, cited in J C Caldwell, 1997 (n 64 above) 178.

when he or she was young.[69] Young boys were often sent to help with agricultural chores and girls were sent to provide domestic help for other relatives who were old or whose children were too young.[70] Such arrangements spread the cost and benefit of child rearing among wider family units.[71] On the one hand, it could mean that relatives are still willing and able to foster children to improve their educational and job opportunities. On the other hand, it may also indicate the growing number of children who are unable to remain with their natural parents because of economic difficulties or death of parents. Caldwell's study in 1997 showed that there were generally more rural-to-urban migrations of children than the other way around.[72] However, recently, children's migration pattern shows a big increase in the urban-to-rural migration.[73]

Rural-to-urban fostering is important in several ways. Rural-to-urban fostering mitigates income inequalities between rural and urban households.[74] A larger and poorer rural household can delegate some of the child rearing cost to a smaller and wealthier urban household.[75] Furthermore, such arrangement may present more educational and economic opportunities for children from rural areas, which, in turn, increases the social mobility of the children.[76] Interestingly, although a rural-to-urban migration of children is more common in many African societies, a recent research shows that an 'AIDS-related migration' is largely urban-to-rural.[77] The reasons could be that the HIV prevalence is higher in urban areas than rural areas. Also many

---

69 N Ansell & L van Blerk, *HIV/AIDS and children's migration in Southern Africa*, Southern African Migration Project (2004) 10.

70 N Ansell & L van Blerk, 2004 (as above) 10.

71 C S Stokes, 'Explaining the demographic transition: Institutional factors in fertility decline' (1995) 60/1 *Rural Sociology* 12.

72 J C Caldwell, 1997 (n 64 above) 179.

73 R Monasch & J T Boerma, 'Orphanhood and childcare patterns in sub-Saharan African: an analysis of national surveys from 40 countries (2004) 18/2 *AIDS* 64.

74 B Bigombe & G M Khadiagala, 'Major trends affecting families in sub-Saharan Africa' available at: http://www.un.org/esa/socdev/family/Publications/mtbigombe.pdf, [accessed: 8 May 2007] 9.

75 B Bigombe & G M Khadiagala (as above) 9.

76 As above 9.

77 N Ansell & L van Blerk, 2004 (n 69 above) 2.

children in urban areas live in nuclear family units. Therefore, when their parents die of AIDS-related illnesses, children often move in with their relatives in rural areas.[78]

However, it is not to say that the fostering arrangement always brings a positive outcome. In many cases, the decision to foster is motivated by the economic productivity of the child.[79] In a study on children affected by the HIV epidemic in Malawi, it has been pointed out that, in some cases, the reason for fostering a child was the desire 'to use the child as an unpaid domestic servant'.[80] Many guardians cited the above reason, among others, for preferring to foster a girl child.[81] Furthermore, fostering does not necessarily guarantee better opportunities for children. For instance, the comparison between non-fostered children and fostered children on primary school enrolment in Burkina Faso shows that fostered children showed a slightly lower enrolment rate.[82] Ainsworth's study in Côte d'Ivoire also shows that fostered children are less likely to be enrolled in school than biological children in the same households.[83] Also, fostered children show a higher rate of housework participation when compared to biological children.[84] Moreover, studies in West and East Africa show that children growing up with non-biological parents have more health and educational problems than non-fostered children.[85]

Other related studies show that the treatment of fostered children also depends on whether the children were 'pulled' to another household, for instance, to be cared for by a childless couple, or 'pushed' to another household, for instance, due to a marital

---

78 N Ansell & L van Blerk, 2004 (as above) 15.

79 G Gibbison & C Paul 'Foster care and the educational attainment of Jamaican children' (2005) 24 *Population Research and Policy Review* 108.

80 G Mann, *Family matters: the care and protection of children affected by HIV/AIDS in Malawi*, Commissioned by Save the Children USA (2002) 29.

81 G Mann, 2002 (as above) 29; In the study, it was also noted that some guardians preferred to foster a girl child in order to marry the child or to benefit from a man who would marry the child.

82 R Akresh, 2005 (n 63 above) 3.

83 M Ainsworth, 'Economic aspect of child fostering in Côte d'Ivoire' (1996) 8 *Research in Population Economics* 25-62 cited in G Gibbison & C Paul, 2005 (n 79 above).

84 G Gibbson & C Paul, 2005 (n 79 above).

85 J P M Ntozi, 'Effect of AIDS on children: the problem of orphans in Uganda' (1997) 7 *Health Transition Review* 24.

breakdown.[86] Oleke *et al.* shows how fostering children who are orphaned differed from the 'exchange of children' in the Langi society in Uganda.[87] The study further shows that children who are orphaned were called '*atin kic*' (meaning orphans in the Langi language) instead of their names indicating their inferior position in the family.[88] A study by Masmas *et al.* in Guinea-Bissau further illustrates how most people in their study 'expect orphans to be stigmatised and neglected within their community'.[89] Such findings clearly illustrate the danger of romanticising the informal foster care of children who are orphaned by relatives. The possible culturally rooted discrimination against children who are orphaned should be taken into account when devising laws or policies on alternative care arrangements. Nonetheless, regardless of the treatment of the fostered children, the culture of fostering provided a certain social safety net for impoverished families and their offspring.

As several studies illustrate above, the burden of caring for orphans, widows, elderly and people with disabilities was shared between the members of extended family.[90] As observed in the Baganda culture, due to the close kinship relationship, there was no occasion for the adoption of orphans as children were thought to belong to the whole extended family network as when their father or mother died, they were always under the care of other relatives.[91] Such traditional care arrangements inadvertently led to the governments' reluctance to intervene, as orphaned and vulnerable children are *expected* to be cared for within the extended family network.[92] Unfortunately, governments have been slow at realising the rapidly changing economic and social

---

86 M Urassa *et al*., 'Orphanhood, child fostering and the HIV epidemic in rural Tanzania' (1997) 7/2 *Health Transitional Review* 151; H R Aspaas, 'AIDS and orphans in Uganda: geographical and gender interpretation of household resources (1999) 36/2 *Social Science Journal* 204.

87 C Oleke *et al.*, '"When the obvious brother is not there": Political and cultural contexts of the orphan challenge in northern Uganda' (2005) 61 *Social Science & Medicine* 2631.

88 C Oleke *et al.*, 2005 (as above) 2631

89 T N Masmas *et al*., 'The social situation of motherless children in rural and urban areas of Guinea-Bissau' (2004) 59 *Social Science & Medicine* 1237.

90 M F C Bourdillon, 1976 (n 53 above) 43.

91 J Roscoe, 1965 (n 16 above); E.E. Evans-Pritchard, *Kinship and marriage among the Nuer*, Clarendon Press: Oxford (1995); Evans-Pritchard also observed that in Nuer, the similar cultural belief that children were considered to have belonged to wider kinship network prevailed. It was observed that a child was born into "a wider circle than the family, in a sense that all those who share the homestead with the father and adjacent homesteads take an interest" in the child's well-being.

92 D Kayongo-Male & P Onyango, 1984 (n 25 above) 88.

circumstances that make it difficult, if not impossible, for the extended family to take on the burden of care.

2.3 Changes in the family structure

The extended family network system worked as an effective social security provider in traditional agricultural societies where the communities were comprised of extended family members working as largely self-sufficient economic units. However, the role of family as a unit of 'production, consumption, reproduction and accumulation' changed as the socio-economic environment in which they operate changed.[93] Living in large extended households was more common in traditional agricultural societies and gradually became less so as societies become more industrialised.[94] Rapid urbanisation, labour migration and development of a cash economy, which are closely linked to the westernisation of a traditional socio-economic structure, brought about the weakening of family ties, and the need to redefine the functions of the African family.[95] However, it is an oversimplification to view the process, and the extent, of the decline of extended kinship ties as a uniform phenomenon across Africa.[96] Depending on the level of industrialisation and urbanisation, the degree of erosion of the extended family network system differs from one society to another. Nevertheless, the commonality across the societies is that an African family network system is changing over time and its reliability as an informal social security provider is weakening.

As mentioned above, the causes of changes in the African family structure vary. These factors cannot be seen as an isolated phenomenon, as they are interrelated. For instance, growing industrialisation based on mineral resources attracts labour forces to

---

93 B Bigombe & G M Khadiagala (n 74 above).

94 Z Zimmer & J Dayton, 2005 (n 23 above) 296.

95 See generally, A B C Ocholla-Ayayo, 1997 (n 8 above); C Oppong, 'African family systems and socio-economic crisis' in A Adepoju (ed) *Family, population and development in Africa*, Zed Books (London & New Jersey: 1997); G Foster *et al*., 'Factors leading to the establishment of child-headed households: The case of Zimbabwe (1997) 7 *Health Transitional* Review 156; N A Apt 'Rapid urbanisation and living arrangements of older persons in Africa', available at: http://www.un.org/esa/populations/publications/bulletin42_43/apt.pdf [accessed: 8 May 2007] 10.

96 A B C Ocholla-Ayayo, 1997 (n 8 above) 71; D Kayongo-Male & P Onyango, 1984 (n 25 above) 34 & 35.

mines, which in turn speeds up the urbanisation. Urbanisation provides more diverse work opportunities for people, which further encourages labour migration from rural to newly urbanised areas. The consequence is that through the process, the African family structure has gradually transformed from 'corporate kinship and extended families towards nuclear families.'[97] Modernisation through industrialisation and the westernised educational system penetrated many communities and individuals in Africa nudging them to embrace a lifestyle that is previously unknown to traditional African societies.[98] In addition to the changes brought about through urbanisation and industrialisation, the HIV epidemic caused major changes to the structure of traditional African family. The impact of the epidemic on the structure of families in severely affected African states is so profound that it grossly limits the ability of the extended family network to perform its traditional function as an informal social security provider. In the following section, the impacts of urbanisation, labour migration and the HIV epidemic on African society and family are explored.

2.3.1 Labour migration

Africa has a long history of migration in search of opportunities and financial advantages.[99] Even before the industrialisation, droughts and floods, which affected the agricultural production, forced millions of people to leave their habitual residence to look for a greener and richer land.[100] With the advance of industrialisation, millions of people were, and still are, lured to mines or collective plantations to supplement the income in rural households. The difference between the previous agricultural migration and the current labour migration practice is the movement of households. In the past, extended families or households may have moved together to find a new area to settle, while current labour migration consists of a smaller family unit or household breaking up from a larger group to form a new unit of production.[101] In other words, the current labour migration movement is individualistic rather than collective.

---

97 B Bigombe & G M Khadiagala (n 74 above) 2.

98 A B C Ocholla-Ayayo, 1997 (n 8 above) 63.

99 S E Findley, 'Migrations and family interactions in Africa' in A Adepoju (ed) *Family, population and development in Africa*, Zed Books (London & New Jersey, 1997) 109; N A Apt, (n 95 above) 3-4.

100 S E Findley, 1997 (as above) 109.

101 See N A Apt (n 95 above) 3-4.

Furthermore, it includes not only rural-to-urban migration but also inter-state migration. Labour migration from poorer and agrarian states like Lesotho, Malawi, Swaziland and Zambia to more industrialised South African mines and factories is a good example.[102] Although such inter-state labour migration is often temporary, the impact on the African family structure has been profound.[103] A reduced number of contacts with family members gradually weakened the ties among units of extended family.[104]

However, labour migration does not only bring negative consequences. It is a response, and may be a solution, to limited employment and educational opportunities in rural areas or less industrialised countries. Labour migration has an important economic function as shown in the case of Lesotho where Basotho mine workers' remittances from South African mines constituted 67 per cent of Lesotho's GDP in the 1990s.[105] It should also be stressed that rural-urban labour movement itself does not necessarily lead to a break-down of rural-urban ties in all cases. Undeniably, the traditional care system that is characterised by inter-generational reciprocal care and support is much affected by the fact that younger generation moves away from its larger extended family unit. Nevertheless, regular urban-to-rural cash remittances and rural-to-urban commodity remittances help maintaining the family ties. The rural-to-urban fostering practice is also a form of remittance, which affirms rural-urban ties.[106]

---

102 B Bigombe & G M Khadiagala (n 74 above) 12.

103 N A Apt (n 95 above) 4.

104 C Murray, *Families divided: The impact of migrant labour in Lesotho* (Cambridge University Press, 1981) 100-103, In page 101, Murray quoted Barker (1973) to express the negative impact of migration on the family ties; "It is at family level that the most pain is felt, and we cannot forget that the African cultural heritage enshrines a broader, more noble concept of family then that of the West. The extended family has proved a marvellous security for those for whom, otherwise, there was no security at all. The extended family is a net wide enough to gather the child who falls from the feeble control of neglectful parents, it receives the widow, tolerates the batty, gives status to grannies. Migratory labour destroys this … "

105 C Sander & S M Maimbo, 'Migrant labour remittances in Africa: reducing obstacles to development contributors', Africa Region Working Paper Series No 64 (November 2003), available at: http://www.worldbank.org/afr/wps/wp64.pdf [accessed: 9 May 2007] 15.

106 B Bigombe & G M Khadiagala (n 74 above) 9.

The weakening of family ties can be attributed to the prolonged economic downturn since 1980s, which makes remittances a burden.[107] For instance, related studies show that during the years of economic decline, rural-to-urban fosterage rate declines, thereby generally undermining rural-urban ties. [108] Furthermore, a prolonged geographical separation among family members inevitably reduces the frequency of contact with relatives, gradually weakening a strong kinship bond.[109]

2.3.2 Urbanisation

It is true that the majority of people in African states still live overwhelmingly in rural areas. However, the volume and constancy of the labour movement from rural to urban areas are unprecedented compared to any other continent.[110] Such scale of labour migration contributes to the rapid urbanisation in Africa. The UN World Urbanisation Prospects 2005 Update shows an average 22 per cent urban growth rate in Africa between 1950 and 1980.[111] It is further projected that by 2015, 42.8 per cent of Africa would be urbanised.[112]

In the urban setting, it became increasingly difficult for an extended family unit to stay together due to the high cost of maintaining a large household with low wages.[113] Furthermore, as an individually controllable cash income increases, the collective economy-based kinship solidarity gradually erodes away. [114] Development of the notion of personal property renders the traditional economic unity of the extended family obsolete.[115] In addition, formal education also contributes in lessening the role

---

107 B Bigombe & G M Khadiagala (as above) 12-14; M Jerven, *Prospects for grouth in Africa: Learning from patters of long-term economic change*, London School of Economics (2010) available at: http://www2.lse.ac.uk/IDEAS/publications/reports/pdf/SU004/jerven.pdf [accessed: 12 July 2010]; C Sander & S M Maimbo, 2003 (n 105 above) 8.

108 B Bigombe & G M Khadiagala (as above) 9-10.

109 C Oppong, 1997 (n 95 above) 162; G Foster, 2005 (n 26 above)

110 N A Apt (n 95 above) 4.

111 UN World Urbanisation Prospects: The 2005 revision population database, available at:http://esa.un.org/unup/p2k0data.asp [accessed: 9 May 2007].

112 UN World Urbanisation Prospects (as above).

113 B Bigombe & G M Khadiagala (n 74 above); D Kayongo-Male & P Onyango, 1984 (n 25 above) 35.

114 C Oppong, 1997 (n 95 above) 162.

115 G Foster, 2005 (n 26 above) 69.

of elders in the family. Social values are taught through schools rather than through traditional mechanisms, further diminishing the educational role of an extended family.[116] The pressure on the traditional kinship structure by the physical separation of family members is aggravated by economic downfalls, an individualistic market economy and an increasing value attached to westernised education.

Labour migration, rapid urbanisation and development of cash economy affected the fundamental 'principles of socialisation and solidarity among the members of kinship network'.[117] Such development brought out changes not only in the form of a family network, but the way members of a family unit relate to each other. In Malawi, in urban areas, it was reported that networks with relatives outside the immediate household were weak.[118] The weak extended family network has reinforced the importance of sibling relations and assistance from friends.[119] While in rural areas, networks with relatives outside of the immediate household were still strong and relatives played a major role in contributing financial and emotional support to the children.[120] Interestingly, the study also highlighted the changing relationship among the family members. For instance, in urban areas, the relationship with a guardian's biological children and fostered children was often characterised as cruel and abusive.[121] However, in rural areas, the relationship between the biological children of a guardian and fostered children was reported to be relatively close and strong.[122]

Together with the labour migration, urbanisation, and the modernised economic and educational system, another related determinant that is affecting the traditional African family structure is the HIV epidemic.[123] The scale of the impact is such that

---

116 G Foster, 2005 (as above) 69.

117 A Adepoju & W Mbugua, 1997 (n 3 above) 71.

118 G Mann, 2002 (n 80 above) 53.

119 As above) 53.

120 As above 53.

121 As above 53.

122 As above 53.

123 *Economic social conditions in Southern Africa 2003: The challenges of private sector development in Southern Africa*, Economic Commission for Africa (2005) 20. On the issue of gender inequality, the report points out that over 50 % of infected people in Africa are women and girls. The report further argues for the need for fundamental shifts in the gender biased mind-set and cultural norms that exacerbate gender inequality and discrimination.

the epidemic is re-shaping demography of the severely affected African societies. The re-structuring and change in the traditional extended family system most severely affects the elderly and children. The increasing number of deaths among the young working generation has two broad implications on the situation of the elderly. First of all, it weakens the traditional inter-generational support, making the older generation financially vulnerable. Secondly, the older generation is often entrusted to take on a role of caring for grandchildren who have lost their parents, thus worsening the situation of the already destitute elderly.[124] In the next section, the impact of the epidemic on African families in relation to the care of children is discussed in detail.

2.3.3 The HIV epidemic

(i) Overview of the impact on the society

> In all countries (in southern Africa) the epidemic is attacking the most productive sectors and prime-aged adults and also robbing economics of scarce skills, children of their parents, and exacerbating food insecurity. HIV/AIDS-induced poverty is intensifying and deepening while, at the same time, demands are increasing for public goods such as health and education.[125]

The impact of the HIV epidemic in sub-Saharan African states is complicated and devastating. At the onset of the epidemic, it was seen as a health condition affecting certain categories of population, such as male homosexuals and intravenous drug users.[126] However, it became clear that the HIV epidemic in Africa is much more general in nature, hence more destructive. The HIV transmission in Africa is mainly through heterosexual intercourse, and the transmission through drug abuse, homosexual intercourse or blood transfusion is relatively small.[127] Precisely because of the heterosexual nature of the epidemic in Africa, it is affecting a wider range of the population including adults who are in their most reproductive and productive stage in their lives, children who are infected by the virus through mother-to-child

---

124 G Bicego *et al.*, 'Dimensions of the emerging orphan crisis in sub-Saharan Africa' (2003) 56 *Social Science & Medicine* 1241.

125 Economic Commission for Africa, 2005 (n 123 above) 20.

126 See A Larson, 'Social epidemiology of Africa's AIDS epidemic' (1990) 89/354 *African Affairs* 5.

127 A Adepoju, 1997 (n 18 above) 16.

transmission during birth or lactation, children who have lost their parents to AIDS and millions of others who are bearing the brunt of the epidemic.

Owing to the multitude of indirectly and directly affected people, the epidemic is predicted to reshape African societies in much the same fashion as the plague outbreak did in medieval Europe.[128] The HIV epidemic has claimed approximately two million lives in 2007 alone in sub-Saharan Africa and in the same year, an estimated 2.7 million adults and children were newly infected with HIV.[129] The lack of access to ART is also a contributing factor to an increasing number of AIDS-related casualties.[130] In any society, a high death toll among the productive work force affects all dimensions of the society. The debilitating impact of the HIV epidemic is manifold and the consequences of the epidemic are hard to analyze separately. General consequences of the epidemic on heavily affected countries include the decreasing rates of GDP, [131] increasing child mortality rates, [132] reduced life expectancy, over-stretched already weak health and educational systems and the breakdown of family structure. [133] On account of such wide implications of the

---

128 'Forty million orphans' in *The Economist* (28 November 2002). The Black Death, which swept through Eurasia, killed one third of the population, marking a grave social change in Europe and Asia; J C Caldwell, 1997 (n 64 above) 169; J C Caldwell, 'The African HIV epidemic: reflections on a research program' (2002) 19/2 *Journal of Population Research* 173.

129 Statistics from the UNAIDS, *Global AIDS epidemic update 2008* (2008) 30.

130 By end of 2008, around 44 % of people in need of ART were receiving the treatment in sub-Saharan Africa. It is a big increase from 17 % in 2005. However, the rate differs across the continent. The number of people on ART varies; in Botswana and Uganda over 50 % of people were getting treatment whereas in Mozambique, only 28 % of people were receiving such treatment. See http://www.avert.org/universal-access.htm [accessed: 23 October 2009]; *Treat 3 by 2005 Progress on global access to HIV antiretroviral therapy: A report on "3 by 5" and beyond*, WHO & UNAIDS (March 2006) 19; UNGASS Report 2008, Mozambique.

131 R Hecht *et al.*, 'Putting it together: AIDS and the millennium development goals' (2006) 3/11 *PLoS Medicine* 1992-1998. It was predicted that in a typical African states with a 20 % or higher prevalence rate would have a 2.6 % lower GDP growth rate each year than would have been the case in the absence of AIDS.

132 In countries that are severely affected by the epidemic, the gains in under-five mortality rates have reversed. In Botswana, the child-mortality rate, which would have been 42 per 1000 live birth without AIDS, is 106 due to AIDS; in Swaziland, 143 as opposed to 73; Lesotho, 123 as opposed to 71; South Africa 74 as opposed to 43 and in Zimbabwe, 117 as opposed to 78. See UNAIDS *Report on the global AIDS epidemic update 2006* (2006) 92.

133 Economic Commission for Africa, 2005 (n 123 above) 20. The epidemic destabilises numerous important institutions such as health, education and military as the HIV and AIDS affects skilled personnel. A study on the HIV prevalence in the education sector found that the prevalence rate among teachers reflects that of national rate, save in Ghana, where the prevalence rate in the education sector was 9.2 % while the national rate was 3 %. J Tamukong, *The impact of HIV/AIDS on teachers and other education personnel in West and Central Africa: A synthesis of the literature from 2000-2004*, Educational Research Network for West and Central Africa,

epidemic, several different levels of analysis can be employed: individual, families, community, and national.[134]

An examination of the recent United Nations General Assembly Special Session (UNGASS) Progress Reports and United Nations Development Programme (UNDP) Human Development Reports (HDR) illustrates the long-term impact of the HIV epidemic.[135] In Botswana, it is projected that after 20 years, the national economy will be 30 per cent smaller than it would have been without the HIV epidemic.[136] In Swaziland, the HIV epidemic is thought to cause a reduction in economic growth between 0.6 per cent and 2.6 per cent.[137] Furthermore, a substantial human resource loss due to HIV-related absentees and AIDS-related death in many African states has been documented.[138]

Increasing human casualties also affect public sectors hindering the effective public service delivery in already resource-challenged countries. The Mozambique National Human Development Report 2007 shows that the HIV prevalence is 17 per cent among qualified health care workers. Also the loss of teachers to the AIDS-related illnesses is increasing and by 2010, Mozambique would have lost 17 per cent of its key staff in the education sector to AIDS-related illnesses.[139] In South Africa, it was reported that 11.5 per cent of health care workers were living with HIV, including 14

Cameroon, (2004) 2; In the first 10 months of 1998, 1300 teachers died of AIDS-related illness in Zambia. Information, available at: http://www.fao.org/FOCUS/E/aids/aids6-e.htm [accessed: 11 June 2007].

134 *Measuring impacts of HIV/AIDS on rural livelihoods and food security*, Food and Agricultural Organisation of the United Nations (2002) 8.

135 The reports examined are: Botswana United Nations General Assembly Special Session on HIV/AIDS Progress Report (UNGASS) 2008, Kenya UNGASS Progress Report 2008, Lesotho UNGASS Country Report 2008, Malawi HIV and AIDS Monitoring and Evaluation Report 2008, South Africa UNGASS Country Report 2008, Swaziland UNGASS Progress Report 2008, Kenya National Human Development Report 2006: *Human Security and Human Development: a deliberate choice*, Malawi National Human Development Report 2005: *Reversing HIV and AIDS in Malawi*, Zambia National Human Development Report 2007: *Enhancing Household Capacity to Respond to HIV/AIDS*, Lesotho National Human Development Report 2006, Mozambique National Human Development Report 2007: *Challenges and Opportunities: the Response to HIV and AIDS*.

136 Botswana UNGASS Progress Report 2008 (as above) 12.

137 A Whiteside & A Whalley, *Reviewing 'Emergencies' for Swaziland: shifting the Paradigm in a New Era* (2007) 34.

138 UNAIDS, 2008 (n 129 above) 177.

139 Mozambique National Human Development Report 2007 (n 135 above) 27.

per cent of nurses.[140] Such high HIV prevalence among health care workers translates into weakened health care systems. The combination of the increasing loss of health care professionals and the dramatically increasing demands of health care services among general population due to the HIV epidemic means that public health care systems will not be able to provide adequate and quality health care to people in need of health care services.[141] Exacerbating the problem are the prohibitive costs of private health care systems which prevent the majority of the population from accessing such health care.

The impact of the epidemic on different levels of a society is interlinked, interdependent and circular. Thus, to fully grasp the changes brought about to the African family structure and its child-care practices by the epidemic, it is imperative to analyse such an impact on the wider community, at the regional and national levels. For instance, macroeconomic impacts of the epidemic, such as decreasing levels of GDP and government revenue, affect the effectiveness and scale of social services provided for people in poverty.[142] Essential social services may include health care provisions, free education and social assistance grants. The lack of, or ineffectiveness of, social services contributes to the increasing level of household poverty which in turn fuels the spread of HIV. Increase in the HIV prevalence again worsens the fall of government revenue. As Barnett and Whiteside acutely pointed out, governments' ability to provide for poverty alleviation and social services will be significantly reduced when the demand for such services is the greatest.[143] Although the importance of exploring the wider impacts of the epidemic is recognised, for the purpose of the section, the central focus of the analysis is limited to the impact of epidemic on the African family and individuals.

---

140 UNAIDS, 2008 (n 129 above) 175.

141 The WHO Health Statistics 2008 shows that in many southern African states, there is a severe lack of health care professionals. For instance in Malawi and Mozambique, less than 1 physician is available per 10 000 people. The regional average is 2 physicians per 10 000 people. Information is available at www.who.org [accessed: 9 September 2008].

142 Tostensen also talks of the irony of the "very phenomena of HIV/AIDS" that undermines the development of an effective social security measures, but reinforces the necessity of reforms and improvement. A Tostensen, 2004 (n 31 above) 10.

143 T Barnett & A Whiteside, 'Poverty and HIV/AIDS: impact, coping and mitigation policy' in G A Cornia (ed) *AIDS, public policy and child well-being*, UNICEF-IRC (June 2002).

(ii) Impact on families and family structure

The HIV epidemic in various African societies has a serious impact on the African family structure. The high mortality rate among the young reproductive working generation means, first of all, a substantial fall in income levels. Rural communities and households directly bear the brunt of the epidemic's impact on labour-intensive sectors, such as agriculture. According to Food and Agricultural Organisation of the United Nations (FAO) estimates, seven million agricultural workers have died from AIDS-related illnesses between 1985 and 2002, and by 2020, a further 16 million agricultural labourers could be lost in sub-Saharan countries.[144] It is also projected that in heavily affected countries, such as Namibia, Botswana, Zimbabwe, Mozambique and South Africa, over 20 per cent of the agricultural force could be lost by 2020.[145] Apart from the loss of productive labour of the afflicted members, other members' labour productivity is also reduced due to the time spent taking care of sick members. At a community level and national level, such loss inevitably contributes to a slowing down of the economy and heightened food insecurity. At an individual and family level, it directly reduces the average income level and dramatically affects the standard of living and health status of other dependents. The World Bank research shows that the impact of a prime-age adult death on poor households is dramatic on food expenditure and food consumption.[146] On average, in poor households, the food expenditure per adult member of the households dropped by 32 per cent.[147] Such a drop in the food expenditure and consumption directly affects health status of the members of the households.

Furthermore, in the absence of public health care services, the cost of medical care is borne individually by family members severely affecting the income levels of

---

144 Food and Agricultural Organisation of the United Nations, 2002 (n 134 above) vii.

145 For more information and statistics, see http://www.fao.org/FOCUS/E/aids/aids6-e.htm [accessed: 11 June 2007].

146 M Ainsworth *et al.*, (eds) *Confronting AIDS: public priority in a global epidemic*, World Bank, European Commission & UNAIDS (1998) available at: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/1997/10/01/000009265_3980219162747/Rendered/PDF/multi0page.pdf [accessed: 17 November 2009].

147 'AIDS and poverty: who needs help?' in M Ainsworth *et al.*, 1998 (as above) 206.

households.[148] A study conducted in Rakai district in Uganda found that when a death of an economically active adult was AIDS-related, the decline in household resource was more acute compared to non-AIDS related deaths.[149] Non-AIDS related deaths of adults had no or little impact on household resources. Although the finding should be accepted with caution and should not be generalised, it shows that AIDS-related deaths have a stronger impact on the household economy. It might be that while trying to meet the health care costs during a long period of illness, the household depletes its savings and other resources.[150] Other research on the income level of HIV-affected and non-affected households also showed a significant difference between the two sets of households. Oni *et al.* found that in the rural Limpopo province of South Africa, which has an estimated HIV prevalence of 21.5 per cent among antenatal attendees, an average annual income of HIV-affected households was 35 per cent lower than that of non-affected households.[151] In the rural Kafue district of Zambia, the average annual income of households affected by chronic illnesses is 46 per cent lower than that of non-affected households.[152]

What makes matters even worse is the secondary consequence of high mortality rates among the younger generation: an increasing number of children who are deprived of their parental care. Naturally, the increasing number of dependents on a reduced level of income increases the financial instability of affected households. For instance, in Botswana, HIV increases the share of household living in poverty by six per cent and every income earner in the group supports an additional eight dependents.[153] In

---

148 *Missing mothers: meeting the needs of children affected by AIDS*, Save the Children: UK (2006) 11.

149 R Menon *et al.*, 'The economic impact of adult mortality on households in Rakai district, Uganda', *Confronting AIDS: evidence from the developing world* (1997) Selected background papers for the World Bank Policy Research Report, M Ainsworth *et al.*, 1997 (n 146 above)*:* 334.

150 *Reversed roles and stressed souls: child-headed households in Ethiopia*, African Child Policy Forum (2008) 36. Children in child-headed households that are affected by AIDS-related illnesses often inherit debt as parents' illnesses deplete household assets.

151 Cited in V Naidu & G Harris, 'The impact of HIV/AIDS morbidity and mortality on households- a review of households studies' (2005) 73 *South African Journal of Economics* 536; Statistics available at http://www.avert.org/safricastats.htm [accessed: 30 May 2007]; Also see *Report on National HIV and Syphilis antenatal sero-prevalence survey in South Africa 2005*, Department of Health of South Africa (2006)10.

152 V Naidu & G Harris, 2005 (as above) 536.

153 UNAIDS, 2008 (n 129 above) 170.

Zimbabwe, nearly 25 per cent of rural households are fostering children who are orphaned.[154] Howard *et al.* aptly observed that 'the dual disaster of AIDS and economic decline is straining the country's primary, preferred, most cost-effective, and previously well-defined and almost fail-safe system of orphan care - the extended family.'[155] Despite that the observation was made in relation to a situation in Zimbabwe, it is equally applicable in other states heavily affected by the epidemic.

Increasingly, a weakened traditional extended family support structure is evidenced by a swelling number of grandparent-headed households and child-headed households.[156] As noted in section 2.2, traditionally, children who are orphaned have been looked after by extended families, especially aunts and uncles.[157] However, due to the high mortality rate among younger generation, the burden of care is often carried out by grandparents or elder siblings who are often children themselves.[158]

Nyamukapa and Gregson's study in rural Zimbabwe indicates that 45.3 per cent of children who lost both parents lived with their grandparents and further 25 per cent of them lived in sibling-headed households.[159] In Ethiopia, 68 per cent of the cases where parents died with AIDS-related illness, children were left with their

---

154 B H Howard *et al.*, 'Barriers and incentives to orphan care in a time of AIDS and economic crisis: a cross-sectional survey of caregivers in rural Zimbabwe' (2006) 6/27 *Bio-medical Central Public Health* 3.

155 B H Howard *et al.*, 2006 (as above) 3.

156 S B Kamerman & S G Gabel, 'Social protection for children and their families: a global overview', delivered at the 'Social protection initiatives for children, women, and families: an analysis of recent experience' UNICEF and the Graduate Program in International Affairs at the New School (30-31 October 2006), available at: www.unicef.org/policyanalysis/files/Social_Protection_for_Children_and_their_Families_-_A_Global_Overview.pdf [accessed: 11 January 2008] 18; also see J P M Ntozi & S Nakayiwa 'AIDS in Uganda: how has the household coped with the epidemic?' (1999) *The Confronting African HIV/AIDS epidemic*, 166, available at: http://htc.anu.edu.au/pdfs/ContinuingHIV/Ntozi_Naka.pdf [accessed: 8 December 2009].

157 G Foster, 'HIV and AIDS: orphans and sexual vulnerability', in P Kilbourn & M McDermid (eds) *Sexually exploited children: working to protect and heal*, MARC Publications (1998) 218.

158 G Foster, 1997 (n 95 above) 155-157; G Foster, 2000 (n 11 above) 59; Such trend is also observed in other heavily affected non-African societies. R M Safman observed that in Thailand, as in sub-Saharan Africa, the death of young adults leaves children in the care of elders without inter-generational support. R M Safman, 2004 (n 1 above) 17; Z Zimmer & J Dayton, 2005 (n 23 above) 306.

159 C Nyamukapa & S Gregson, 'Extended families and women's roles in safeguarding orphans' education in AIDS-affected rural Zimbabwe (2005) 60 *Social Science & Medicine* 2159.

grandparents.[160] In Zambia, an estimated 20 per cent of children are orphaned and over seven per cent of Zambian households are headed by child younger than 14 without an adult member.[161] In Swaziland, where the adult HIV prevalence is nearly 40 per cent, so far 70 000 children, which is around eight per cent of the total population, have lost their parents to AIDS and an estimated 15 000 or more households are headed by children who are left to fend for themselves with little help.[162] It is a huge increase from 10 664 households in 2002.[163] The worst is yet to come, as the number of children who have been orphaned is expected to reach 120 000, approximately 15 per cent of total population in Swaziland, by 2010. Also in South Africa, the overall number of children in 'child-headed households' increased from 118 000 in 2002 to 148 000 in 2007.[164] Although the statistics indicate that the proportion of the children living in child-headed households is still small, the existence of, and an increasing number of, child-headed households pose a serious and important challenge to all stakeholders including policy and law-makers and service-delivery agencies because of the particular vulnerabilities of these households.[165]

The increase in such unconventional forms of households is also attributable to economic factors. Arnab and Serumaga-Zake argue that people are increasingly reluctant to bear the burden of caring for children who are not their own because of the financial insecurities they already face.[166] A study by Oleke *et al.* shows a sharp

---

160 UNICEF-IRC, 2006 (n 59 above) 19.

161 UNAIDS, 2008 (n 129 above) 164; B Rau, 'Combating child-labour and HIV/AIDS in sub-Saharan Africa: a synthesis report', No 1, ILO (2003) 30.

162 Statistics are available at: www.unaids.org [accessed: 15 January 2009]; 'Swaziland: young heroes website appeals for help for AIDS orphans' *IRIN news* (14 February 2006) available at: http://www.aegis.com/news/irin/2006/IR060234.html [accessed: 20 February 2009].

163 *Caring for children affected by HIV and AIDS*, UNICEF-Innocenti Research Centre (IRC) (November 2006) 25.

164 Statistics are available at: http://www.childrencount.ci.org.za/content.asp?PageID=68 [accessed: 20 October 2009]. The definition employed for the purpose of the statistics is children living in 'a household in which all members are under 18.' Therefore, it does not include children living with incapacitated adult thereby performing a *de facto* head of household.

165 B Rau, 2003 (n 161 above) 30; it is noted, in the report, that children in child-headed households and grandparent-headed households suffer from health-related issues. See B Rau, 2003 (n 32 above) 7.

166 R Arnab & P A E Serumaga-Zake, 'Orphans and vulnerable children in Botswana: the impact of HIV/AIDS' (2006) 1/3 *Vulnerable Children and Youth Studies* 222.

increase in the number of female-headed households in a strongly patrilineal Lango society in Northern Uganda.[167] It can be attributed to the decrease in wife-inheritance practice due to an increasing awareness of the mode of the transmission of HIV and the conversion to Christianity.[168] In addition, the authors argue that the decrease in the wife-inheritance can also be explained as being due to economic downfall.[169] Poverty and death of potential *laku* (widow inheritance) partners due to AIDS-related illnesses means that the wife-inheritance is often not an option for the widow and her dependent children, leaving them with limited or no social and economic support from their in-laws.[170]

Other reasons that may lead to the establishment of child-headed households include the unwillingness or inability of relatives to care for the children, the preferences of children themselves or dying parents that children should remain on their own, and the death of single mothers especially if the children were not recognised as born of married parents.[171] No matter what the reasons are, research points out that children in grandparent- (often grandmother) headed or child-headed households are most likely to suffer from material difficulties.[172] A study on the impact of the HIV epidemic on children in the Rakai district in Uganda, showing that only 19 per cent of children continued with uninterrupted schooling, is a striking illustration.[173] The study further shows that only seven per cent of children in grandparent-headed households continued with their education.[174] Another study in Uganda shows that children in grandparent-headed households are particularly vulnerable to malnutrition and

---

167 C Oleke *et al*., 2005 (n 87 above) 2635, In patrilineal society like Lango, the customs like widow-inheritance (laku) made sure that the widows and orphaned children were taken care by deceased husband's family network.

168 C Oleke *et al.*, 2005 (as above) 2635; the practice of wife-inheritance varies from community to community and culture to culture. However, in general, the practice involves a male relative of the dead husband, often a brother, takes over the widow was a wife. See, http://www.hrw.org/campaigns/women/property/qna.htm#12 [accessed: 4 November 2010].

169 C Oleke *et al.*, 2005 (as above) 2635.

170 C Oleke *et al.*, 2005 (as above) 2636.

171 See generally G Foster, 2004 (n 15 above).

172 R Arnab & P A E Serumaga-Zake, 2006 (n 166 above) 223; G Foster, 'HIV and AIDS' (n 157 above) 219.

173 R Basaza & D Kaija, 'The impact of HIV/AIDS on children: lights and shadows in the "successful case" of Uganda', in G A Cornia (ed) *AIDS, public policy and child well-being*, UNICEF-IRC (June 2002) 48.

174 R Basaza & D Kaija, 2002 (as above) 48.

infectious diseases.[175] In addition to the economic vulnerability, children in grandparent-headed households may experience multiple losses of primary caregivers, which can have a serious impact on their psychological health.[176]

The emergence and increasing number of child-headed households and street children[177] seem to illustrate the breakdown of a traditional form of child care or an over-saturated extended family capacity which can no longer absorb children who are orphaned. The change in the traditional form of child care is an indirect result of the changes in the traditional extended family network system. Urbanisation, labour migration and development of a more individualistic economic system weakened the traditional bond between different units of extended family. In addition to that, the dramatic increase in the number of children who are in need of alternative family care as the epidemic takes its toll means more and more children will become 'social orphans' - a concept that did not exist in many African societies. Although the HIV epidemic is not the only factor that negatively affects the realisation of children's rights and well-being, it is the main factor that makes such a daunting task even more daunting.

(iii) Children in times of AIDS

As illustrated above, the high prevalence of HIV, AIDS-related illnesses and deaths in many sub-Saharan African states have created a long-term public health, social and economic crisis, which affect all levels of society: individuals, families, communities and states. Children are one of the most vulnerable groups. Safman argues that children are often more vulnerable to family crises than adults because they are not in

175 T Barnett & P Blaikie, *AIDS in Africa: its present and future impact* (London: Belhaven, 1992) cited in R M C Evans, 'Social networks, migration, and care in Tanzania' (2005) 11/2 *Journal of Children and Poverty* 115.

176 R M C Evans, 2005 (as above) 115.

177 G Foster, 2004 (n 15 above); The CRC Committee also noted the increasing number of street children in various countries in Africa. See Concluding observation by the CRC Committee: Angola (CRC/C/15/Add.246, 2004) para 68; Concluding observation by the CRC Committee: Senegal (CRC/C/SEN/CO/2, 2006) para 58; Concluding observation by the CRC Committee: Ghana (CRC/C/GHA/CO/2, 2006) para 63; Concluding observation by the CRC Committee: Côte d'Ivoire (CRC/C/15/Add.155, 2001) para 57; Concluding observation by the CRC Committee: Nigeria (CRC/C/15/Add. 257, 2005) para 69; Concluding observation by the CRC Committee: Lesotho (CRC/C/15/Add. 177, 2002) para 52; Concluding observation by the CRC Committee: DRC (CRC/C/COD/CO/2, 2009) 76; Concluding observation by the CRC Committee: Cameroon (CRC/CMR/CO/2, 2010) para 71.

a position to protect or disassociate themselves from the problems.[178] In the majority of African states, the situation of children's rights had been precarious even before the epidemic, and with the epidemic, even the progress made in the areas of education and health is being reversed.[179] The situation in Zambia illustrates a general trend in many African states. In Zambia, the proportion of stunted children has increased from 40 per cent in 1990 to 50 per cent in 2005, and the primary educational enrolment rate has decreased from 80 per cent in 1990 to 78 per cent in 2005.[180]

Furthermore, because children's development is time-dependent, the social, educational and health consequences of such a crisis can be more serious and longer-lasting for children than for adults.[181] For instance, one of the inevitable consequences of death of a primary income-earning adult in household or an increased number of dependents on a limited household income is reduced food expenditure and consumption. Reduced food expenditure and consumption is directly related to childhood malnutrition. Childhood malnutrition affects the healthy development of the child, both intellectual and physical. The effect is long-lasting and profound, especially when the child is young. Also deprivation of parental affection could also have a long-term emotional and psychological consequence on children.

The most obvious groups of children whose rights have been grossly infringed by the epidemic are children who are living with HIV, children whose parents are directly affected by the epidemic and children who are deprived of their parental and family environment. Often these three categories overlap. Considering the main mode of the HIV transmission in children under 15 is through mother-to-child transmission, children who are living with HIV are likely to have parents who are also living with HIV. The most recent UNAIDS AIDS epidemic update indicates that more than 14

---

178 R M Safman, 2004 (n 1 above).

179 R Hecht *et al.*, 'Putting it together: AIDS and the millennium development goals' (2006) 3/11 *PLoS Medicine* 1992; The rate of GDP growth in a typical African state with 20 per cent HIV prevalence would be 2.6 per cent lower each other than it would have been in the absence of AIDS. It was found in six affected countries, child nutrition rapidly deteriorated in the presence of high HIV prevalence. In Mozambique, the percentage of underweight children rose from five per cent to 20 per cent between the years 1997 and 2002.

180 Zambia National Human Development Report 2007 (n 135 above) 20.

181 See L Sherr, *Young children and HIV/AIDS: mapping the field*, Working papers in early childhood development, Bernard van Leer Foundation (2005).

million children lost their parents to AIDS-related illnesses[182] and the number of children who lost both of their parents to AIDS is also increasing sharply. Studies show that the prevalence of children who have lost both parents is disproportionately high in severely affected countries.[183] Bicego *et al.* found that in countries in East and Southern Africa, the regions most severely affected by the epidemic, 10 to 17 per cent of all orphaned children lost both parents, while in West and Central Africa, only four to eight per cent of children who are orphaned lost both parents.[184]

Moreover, the time lag between the infection of HIV and the death from AIDS-related illnesses means the number of children who are orphaned will increase for some years even after the fall of HIV prevalence. In Thailand, for example, despite the reduced HIV prevalence since 1995, the number of children who are orphaned has risen eight fold.[185] Another similar example can be found in Uganda. Despite that the HIV prevalence declined from 14 per cent in the late 1980s to an estimated 5 per cent in 2001, the number of children who are orphaned by AIDS continued to increase until 2001.[186] Unfortunately, in the majority of countries the HIV epidemic has not reached its peak and it is argued that the AIDS-related mortality rate will not be stabilised till 2020.[187] It means that the number of children orphaned by AIDS-related illnesses will increase at least until 2030.[188]

---

182 *AIDS epidemic update 2009*, UNAIDS (November, 2009), available at: http://data.unaids.org/pub/FactSheet/2009/20091124_FS_global_en.pdf [accessed: 12 July 2010].

183 G Bicego *et al*., 2003 (n 124 above) 1237; R Monasch & J T Boerma, 'Orphanhood and childcare patterns in sub-Saharan Africa: an analysis of national surveys from 40 countries' (2004) 18/2 *AIDS* 57; Monasch and Boerma showed that in Zambia, the percentage of children who lost both parents among all children who are orphaned rose from 8 % to 19 % between 1992 and 2001 and in Zimbabwe, the figure also rose from 8 % to 15 % between 1994 and 1999. See table 2 Orphans as a percentage of all children under 15 years of age, countries with trend date by different HIV prevalence levels.

184 G Bicego *et al.*, 2003 (as above) 1237.

185 G A Cornia, 'Overview of the impact and best practice responses in favour of children in a world affected by HIV/AIDS' G A Cornia (ed) *AIDS, public policy and child well-being*, UNICEF-IRC (June 2002) 11.

186 G Andrews *et al.*, 'Epidemiology of health and vulnerability among children orphaned and made vulnerable by HIV/AIDS in sub-Saharan Africa (2006) 18/3 *AIDS Care* 271. In 2001, 14.6 per cent of all children in Uganda were orphaned children. The number gradually declined and in 2010, an estimated 2.5 million children are orphaned and among them 1.2 million are estimated to be orphaned by AIDS. Statistics available at: http://www.unicef.org/infobycountry/stats_popup4.html [accessed: 15 July 2010].

187 C Levine & G Foster, *The white oat report: building international support for children affected by AIDS*, New York: the orphan project (2000) cited in K Subbarao & D Coury, *Reaching out to*

In addition to the swelling number of children losing their parents to AIDS-related illnesses, another tragic aspect of the HIV epidemic is the increasing number of children who are abandoned. A study in Thailand shows that children of mothers who are living with HIV are five times more likely to be abandoned than other children.[189] In the absence of strong social support, HIV-related poverty, stigmatisation, social isolation and inability to care for children who are living with HIV are factors inducing abandonment. Desmond and Gow also reported the increasing number of abandoned babies in South Africa as the epidemic takes its toll.[190]

Another category of children who may not have been directly affected by the HIV epidemic but are equally vulnerable are children who have been orphaned by non-AIDS related causes and children whose households are taking care of children who are orphaned. Notwithstanding that they have parental care, their welfare is also grossly compromised as the number of dependents increases in their households. While they may not have been directly affected by the HIV epidemic, as the epidemic depletes the general resource capacity of communities, children may find themselves in an equally dire situation as the children who are orphaned by AIDS. Consequently, focusing on resources for children who are orphaned by AIDS at the expense of other vulnerable children or singling them out for social services is not desirable.[191]

However, an AIDS-related death in a household seems to lead to a deeper level of problems than a non-AIDS-related death. A study in Siaya district in Kenya showed that children who are orphaned by AIDS-related deaths were more likely to be withdrawn from school, more likely to fall ill over the observed period and more

---

Africa's orphans: a framework for public action, African Regional Study Series, World Bank (2004) 7.

188 K Subbarao & D Coury, 2004 (as above) 7.

189 G A Cornia, 2002 (n 185 above) 12.

190 C Desmond & J Gow, 'The current and future impact of the HIV/HIV epidemic on south Africa's children', G A Cornia (ed) *AIDS, public policy and child well-being,* UNICEF-IRC (June, 2002) 19.; Also see 'Charities report sharp rise in number of abandoned South Africa babies' *Guardian.co.uk,* (14 June 2009), available at: http://www.guardian.co.uk/world/2009/jun/14/babies-abandoned-south-africa [accessed: 29 July 2009]. The alternative care related issues concerning abandoned babies are dealt with in chapter 4.

191 UNICEF-IRC, 2006 (n 59 above) 24.

likely to be discriminated than children who are orphaned by other causes.[192] Furthermore, children whose parents suffer from AIDS-related illness experience a deeper level of poverty than other children.[193] The loss of income through illness as well as increased medical expenditure, often leave children who lost their parents to AIDS in debt.[194] A study conducted in Cape Town also reported similar findings. The study found that children who were orphaned by AIDS were less likely to be enrolled and more likely to experience food insecurities than children who were orphaned by other causes.[195] Furthermore, children who are orphaned by AIDS were less likely to access basic social services, including social grants compared with other children.[196]

Apart from the financial difficulties, emotional and psychological burdens on children who are losing their parents to AIDS-related illnesses may have more serious and longer lasting effects. Prolonged illness incapacitates parents and children are often pushed to take on a role of *de facto* primary caregivers for their ill parents and younger siblings. As Barnett and Whiteside point out, the care of ill parents goes beyond doing house chores or looking after younger siblings.[197] As AIDS-related illnesses debilitate parents, children often have to provide culturally sensitive care, such as toileting or bathing of parents and often need to cope with parents' mood swings and declining mental capacity.[198] The psychological burden on children who are providing care cannot be exaggerated. Therefore, children who are orphaned by AIDS may need a different type and scale of intervention. Importantly, AIDS-related causes are increasingly becoming a major cause of orphanhood in many southern African states. In some of the severely affected countries, such as Zimbabwe,

---

192 B O Kóyugi & J Muita, 'The impact of a growing HIV/AIDS epidemic on the Kenyan children', G A Cornia (ed), *AIDS, public policy and child well-being*, UNICEF-IRC (June 2002) 9.

193 *Enhanced protection for children affected by AIDS: a companion paper to Framework for the protection, care and support for orphaned and vulnerable children living in a world with HIV and AIDS*, UNICEF (2007) 13.

194 African Child Policy Forum, 2008 (n 150 above) 36.

195 L Cluver *et al.*, 'Poverty and psychological health among AIDS-orphaned children in Cape Town, South Africa' (2009) 21/6 *AIDS Care* 735.

196 L Cluver *et al.*, 2009 (as above).

197 T Barnett & A Whiteside, 2002 (n 143 above) sec 5.8.

198 T Barnett & a Whiteside, 2002 (as above) sec 5.8.

Botswana, Swaziland and Lesotho, over 60 per cent of children who are orphaned lost their parents to AIDS-related illness.[199]

A study by Beegle *et al.* found that orphanhood has a permanent impact on children in terms of their educational level and height in adulthood.[200] According to the Rwanda National Plan of Action for Orphans and Other Vulnerable Children 2008-2011, among 10 to 14 year old children who are orphaned, only 74 per cent of children were attending school compared with 89 per cent of non-orphaned children in the same age group.[201] In Kenya, 88 per cent of children who lost both parents were in school compared with 92 per cent of children with both parents.[202] The result should be interpreted carefully due to the difficulties of controlling variables that may affect the results in longitudinal studies. Nevertheless, the study shows the importance of an active and early intervention in orphanhood as children's development is often negatively affected by the loss of parents, and such negative impact can be long-term.[203]

Extended families more often than not take in children who have lost their parents. However, as pointed out in the earlier section, as the capacity of extended families to absorb children who are orphaned is dwindling, an increasing number of children will become street children or live in child-headed households.[204] The increasing number of children in child-headed households and street children is a great concern as those children are often in the most vulnerable situation. Children in child-headed

---

199 Statistics are available at: http://www.avert.org/aidsorphans.htm [accessed: 25 June 2007].

200 K Beegle *et al*., *Orphanhood and the long-run impact on children*, World Bank (September 2005). K Beegle *et al.* found that, in terms of the educational loss, the effect of orphanhood was greater among maternal orphans compared to paternal orphans.

201 National Plan of Action for Orphans and Other Vulnerable Children 2008-2011, Government of Rwanda, 13.

202 National Plan of Action for Orphans and Vulnerable Children (OVC) 2005/06-2009/2010, Republic of Kenya, 6.

203 K Beegle *et al*., 2005 (n 200 above) 20-22.

204 The Nelson Mandela Study by HSRC found that 3 % of households were headed by children aged between 12 and 18. In urban areas where the HIV prevalence was highest, the figure increased to 4.8 %. Cited in R Mabala, 'From HIV prevention to HIV protection: addressing the vulnerability of girls and young women in an urban area' (2006) 18 *Environment and Urbanisation* 419; A Bhargave & B Bigombe, 'Public policies and the orphans of AIDS in Africa' (2003) 326 *British Medical Journal* 1388, The authors argue that although foster care by extended family members is important, without subsidies, many children will end up in orphanages.

households or in impoverished households face similar problems including food insecurity, difficulty in accessing education or health services, and inadequate housing conditions.[205] However, those problems in child-headed households may be more severe and perpetual because children are often not equipped to work full-time as adults; they are often not in a position to negotiate fair wages; and children who are orphaned have a relatively lower level of education.[206] Most importantly, such problems must be faced without adult supervision and assistance.[207]

Abebe and Aase suggest that child-headed households are not permanent features and adult co-residents eventually take on the responsibility of caring for the children when the biological parents die.[208] However, such an assertion seems to be far removed from reality. There are numerous reports indicating the increasing number of child-headed households in the context of the HIV epidemic.[209] Such reports also indicate that many child-headed households eventually dissolve as children become street children. The Ethiopia National Plan of Action on Orphans and Vulnerable Children states that the HIV pandemic has 'tremendously increased the number of child-headed households and changed cultural patterns of child care and put an incredible strain on the social safety net'.[210] In Rwanda, there were 100 956 children living in child-headed households.[211] The figure is much higher than children in formal alternative care. The same report stated that 28 341 children were in foster care and 3 475 were in institutions.[212] Such figures suggest that a practical and long-term plan to support and protect children in child-headed households is necessary.

---

205 G Foster, 2004 (n 15 above) 72; S Tsegaye, 2008 (n 14 above) 6, 21 & 22; also see African Child Policy Forum, 2008 (n 150 above).

206 R Arnab & P A E Serumaga-Zake, 2006 (n 166 above) 223.

207 G Foster, 2004 (n 15 above) 72.

208 T Abebe & A Aase, 2007 (n 58 above) 2064.

209 R M C Evans, 2005 (n 175 above) 121; UNICEF-IRC, 2006 (n 59 above) 16; 'In the shadow of death: HIV/AIDS and children's rights in Kenya' (June 2001) 13/4A *Human Rights Watch Report*; Also see M A Ayieko, *From single parent to child-headed households: the case of children orphaned by AIDS in Kisumu and Siaya districts in Kenya*, Study paper No 7, HIV and Development Programme, UNDP.

210 Orphans and Vulnerable Children National Plan of Action 2004-2006, Federal Democratic Republic of Ethiopia, 1.

211 National Plan of Action of Rwanda (n 201 above) 14.

212 As above 13-14

So far the chapter highlighted the impact of the HIV epidemic in Africa on different levels of society. It is clear that the epidemic affects all levels and aspects of societies. The consequences of high mortality rates among adults in their most productive and reproductive age, decreased income levels combined with an increased dependency rate, and the subsequent diminished capacity of communities and extended families to absorb economic shocks is also clear. The next question may be whether and how African families are 'coping' and the understanding of the concept of 'coping strategies'.

2.3.4 Coping by providing 'good enough care'?

Some of the earlier research suggested that despite the hardships, extended families were resilient and 'coping'.[213] The concept of 'coping' and 'coping strategy' should be examined carefully to distinguish between 'surviving' and 'coping'. Ansell and Van Blerk listed an early marriage of a child and child migration as forms of 'coping strategy'.[214] A marriage of a child could bring economic benefit to the girl's paternal relatives where a payment of bride wealth is still observed. A marriage could also provide the child with shelter and other material needs.[215] Child migration, whether local or long-distance, is a way to seek shelter and care when a household is dissolved by various reasons. For children, whose parents have died, it might be the only way to survive. However, as Ansell and Van Blerk pointed out, a marriage, more often than not, signals the end of education for girls.[216] They also noted that child migration due to an AIDS-related cause could put young migrants at risk of being mistreated and abused by their foster carers.[217] Evans listed some of the coping strategies adopted by child-headed households to illustrate their resilience.[218] The list includes agricultural

---

213 J C Caldwell, 1997 (n 64 above); M Urassa *et al.*, 1997 (n 86 above); G Foster, 'Beyond education and food: psychosocial well-being of orphans in Africa' (2000) 91 *Acta Paediatr*; see S Madhavan, 'Fosterage patterns in the age of AIDS: continuity and change' (2004) 58 *Social Science & Medicine* 1449.

214 N Ansell & L van Blerk, 2004 (n 69 above) 2-3 & 23.

215 As above 23-25.

216 As above 25.

217 As above 2-3; A study by Hosegood *et al.* in KwaZulu-Natal shows that children from households affected by AIDS are more likely to move. Cited in *Understanding the needs of orphans and other children affected by HIV and AIDS in Africa: state of the science*, US Agency for International Development, Working draft (April 2005) 26.

218 R M C Evans, 2005 (n 175 above) 111-129.

labour after school hours, reducing the household's food consumption, and asking for money from neighbours and friends.[219] Human Rights Watch report on Kenya states that 'withdrawing children from school' is a common coping mechanism for families affected by the HIV epidemic.[220]

In such cases, it is hard to understand how a strategy that potentially limits rights of children can be seen as a 'coping strategy'. 'Coping strategy' or 'coping mechanisms' can only be valid when a community or household maintains its capacity to meet children's needs at some culturally acceptable level.[221] When such strategies or mechanisms clearly pose dangers to children's wellbeing and rights, they are not 'coping strategies' but mere 'survival strategies'. As Barnett and Whiteside pointed out, the term , 'coping', may be 'a way of escaping from the challenge of confronting how people's capabilities are stunted, their entitlements blocked and their abilities to function as full human beings with choices and self-definitions frustrated.'[222]

Increasingly, despite the earlier confidence that extended families would cope, it became evident that many households do not cope but merely survive. Children are increasingly mistreated by relatives, deprived of their inheritance, forced to discontinue their education to become children labourers.[223] As the report on Kenya by Human Rights Watch eloquently argues, 'children should not have to steal, turn to prostitution, or engage in other forms of labour' to survive.[224] Providing daily survival needs of children is the responsibility of parents or guardians. However, when children are deprived of parental care and family environment, it becomes the responsibility of the state to ensure such needs are met.[225]

Foster argues that in times of the current 'orphan crisis', the concept of 'good enough' standards is worthy of consideration in countries where the proportion of children

---

219 As above 119.

220 Human Rights Watch, 2002 (n 209 above) 7.

221 T Barnett & A Whiteside, 2002 (n 143 above) sec 5.15.

222 T Barnett & A Whiteside, 2002 (n 143 above) sec 5.15.

223 Rajaraman (2001) cited in T Barnett & A Whiteside, 2002 (n 143 above) sec 5. 13.

224 Human Rights Watch, 2002 (n 209 above) 16.

225 As above 16.

who are orphaned is over ten per cent.[226] 'Good enough' standards can be understood as standards that are 'appropriate to the norms of the community in which the child lived'.[227] In times of 'orphan crisis', as Foster terms it, it might be an important part of a 'coping strategy' to minimise the administrative hurdles and lower the minimum standards set for formal fostering to enable poor but willing community members to provide 'good enough' care for children.[228]

However, the concept of 'good enough care' is vague. Due to the vagueness of the concept, it is open to misapplication. Barnett and Whiteside criticise the concept as being an attempt to sensitise social workers to the idea that 'while their client's standards of care might appear inadequate by their own social and cultural standards, the clients' was "good enough" as long as everyone was "coping"'.[229] Studies suggest the danger of romanticising the tradition of fostering by relatives. Being looked after by family members does not guarantee that children are being 'well-looked after'.[230] When children are taken in by their relatives because of the family obligation rather than genuine affection, the children are in a greater danger of being mistreated or abused by their carers than otherwise. Ansell and Van Blerk showed that Malawian children considered discrimination and ill treatment by foster families as the worst problems they face.[231] Furthermore, as it is impossible for a poor family to foster a large number of siblings, children are often separated among different households.[232] Separation of siblings can have a negative effect on children who are already traumatised by the death of parents.[233]

The heroic efforts of communities and extended families to 'cope' with the current crisis should be acknowledged. However, over-reliance on extended families'

---

226 G Foster, 2004 (n 15 above) 87.

227 As above 87.

228 As above 87.

229 T Barnett & A Whiteside, 2002 (n 143 above) sec 5.15.

230 UNICEF-IRC, 2006 (n 59 above) 19.

231 N Ansell & L van Blerk, 2004 (n 69 above) 36.

232 UNICEF, 2007 (n 174 above) 15.

233 K Subbarao & D Coury, 2004 (n 187 above) 29; UNICEF, 2007 (n 193 above) 15; Also see paras 17 and 62 of the 2009 United Nations Guidelines for the Alternative Care of Children, (A/HRC/11/L.13), adopted at the UN General Assembly on 20 November, 2009.

capacity to 'cope' or romanticising a traditional model of care could subject children to the danger of exploitation and abuse. Accepting 'good enough care' delays the governmental intervention and the development of new initiatives to provide 'good care' to children who are deprived of their parental and family care.

2.4 Conclusion

It has been claimed that the concept of 'social orphan' did not exist in Africa.[234] It has been also claimed that in African culture, as soon as children are in need, they would be cared for in the community.[235] It is true that traditionally, children who have been deprived of their parental care have been cared for by the extended families and the need of formal intervention had been minimal.[236] However, another side of the truth is that increasingly, many children have experienced hardships and inadequate care in communities. In some cases, the children suffer from inadequate standard of care within their extended family setting.

The chapter explored the changing circumstances, which render providing traditional form of care to children who are deprived of their family environment within extended family network, problematic. It highlighted the role of extended families in traditional African societies and how the caring role has changed over time with other changing social factors, and especially, in the face of increasing socio-economic pressure on the capacity of extended families to provide adequate care to children who are deprived of their parental care in the context of the HIV epidemic. The increasing number of children living in households containing only siblings in the areas where the HIV epidemic has taken its toll indicates that the capacity of extended families has reached 'maximum capacity'.[237] Nevertheless, it has been argued that extended families still absorb the majority of the children who are orphaned by AIDS or

234 D Skinner *et al.*, *Defining orphaned and vulnerable children*, Human Science Research Council of South Africa (2004) 9; G Foster, 2004 (n 15 above) 67.

235 D Skinner, *et al.*, 2004 (as above) 9.

236 T Abebe & A Aase, 'Children, AIDS and the politics of orphan case in Ethiopia: The extended family revisited' (2007) 64 *Social Science and Medicine* 2059.

237 N Dalen *et al.*, '"They don't care what happens to us." The situation of double orphans heading households in Rakai District, Uganda' (2009) 9 *Bio-Medical Central Public Health* 322.

children who are single orphans continue to live with their surviving parents.[238] It has also been argued that families and communities are amazingly resilient in times of crisis and develop various coping strategies to deal with the increasing care burden.[239]

However, a substantial increase in a number of maternal, paternal and double orphans living in households headed by grandparents shows the shift in the child care within the extended family network.[240] Grandparent-headed households are considerably vulnerable economically and there is a danger of children will eventually assume the role of a *de facto* caregiver, due to the old age of their purported caregivers.[241] The deteriorating health of elder caregivers may lead to the dissolution of the household or the establishment of child-headed households, requiring a stronger government intervention in this regard.[242] Moreover, in many cases, the coping strategies, which include children having to contribute to the household livelihoods as 'producers, carers, homemakers and decision-makers', may be detrimental to the well-being and development of the children.[243]

Despite the international as well as the domestic legal and policy framework protecting the rights of the children who are deprived of their family environment, such children are often vulnerable to marginalisation and violation of their rights, including the deprivation of their inheritance.[244] Children in child-headed households are particularly vulnerable to various kinds of maltreatments and abuses.[245] Children in child-headed households, especially children in unaccompanied child-headed households are, at a higher risk of being subject to different types of abuses and

238 C Ardington & M Leibbrandt, 'Orphanhood and schooling in South Africa: trends in the vulnerability of orphans between 1993 and 2005' (2010) 58/3 *Economic Development and Cultural Change* 513.

239 T Abebe & A Aese, 2007 (n 234 above) 2060.

240 C Ardington & M Leibbrandt, 2010 (as above).

241 G Foster *et al.*, 1997 (n 95 above) 160; G Foster, 2004 (n 15 above) 70-71.

242 G Foster, *et al.*, 1997 (as above); G Foster, 2004 (as above).

243 T Abebe & M Skovdal, 'Livelihoods, care and the familial relations of orphans in eastern Africa' (2010) 22/5 *AIDS Care* 573.

244 D Skinner, *et al.*, 2004 (n 233 above) 10.

245 See African Child Policy Forum, 2008 (n 150 above); S Tsegaye, 2008 (n 14 above); N Dalen *et al.*, 2009 (n 237 above).

maltreatment by their relatives, neighbours and employers.[246] The increasing trends to recognise child-headed households as an option of care calls for the establishment and implementation of a stronger legal and policy framework to protect the rights of children who are deprived of their family environment, and in particular, the rights of children living in child-headed households.

In the following chapter, the international legal and policy framework protecting the rights of children who are deprived of their family environment is explored. The analysis of the right to alternative care, and special protection and assistance protected under the CRC and the ACRWC in particular, form the major part of the discussion. The chapter also explores the existing forms of alternative care placements and the emergence of child-headed households as a recognised form of care.

246 African Child Policy Forum, 2008 (n 150 above).