UNFOLDING TRAGEDIES: THE IMPACT OF A MOTHER'S DEATH ON HER KIN AND COMMUNITY. AN ETHNOGRAPHY FROM SOUTHERN MALAWI

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ABSTRACT

In examining the specific impact of a mother's death on her surviving family and community, the thesis highlights the social devastation resulting from such an event. Crucially, it argues that the increased frequency of maternal death associated with the HIV/AIDS epidemic, and the associated increase in numbers of orphaned children, have the potential to provoke full-scale destruction of traditional kinship structures and coping mechanisms.

The study contributes to a gendered study of death and the resultant coping mechanisms as well as emphasizing the importance of sibling bonds in Malawian kinship. Furthermore, it provides an analysis of the current trends relating to orphan care, and suggests how these goals could be improved within the specific cultural context.

The findings are based on 14 months of in situ fieldwork, during which time a total of 78 interviews were conducted with 66 individuals, 46 of whom are case studies. Further interviews were conducted with hospital personnel, workers with orphans, and teachers, i.e. those in positions to provide social commentary. Nudist N4 software was used for data management of the interview transcripts and fieldnotes, and facilitated access to the coded data as analysis proceeded.

An historical understanding of Malawi's cultural context is outlined in the introductory chapter and the entire discussion is grounded within this context. More-detailed anthropological data is provided in the chapter on kinship, which emphasizes the importance of maternal kin in looking after orphans subsequent to a mother's death. Chapters on HIV and death outline how communities are besieged by illnesses surrounding HIV-infection, and how the increased death rates associated with HIV have undermined the traditional bereavement processes and, hence, the associated coping mechanisms.

The thesis concludes with a discussion of the kinds of orphan care currently available in Malawi, followed by recommendations on how the needs of orphans could better be met by development initiatives that are more suited to working with community-based organizations.

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LIST OF ABBREVIATIONS AND ACRONYMS

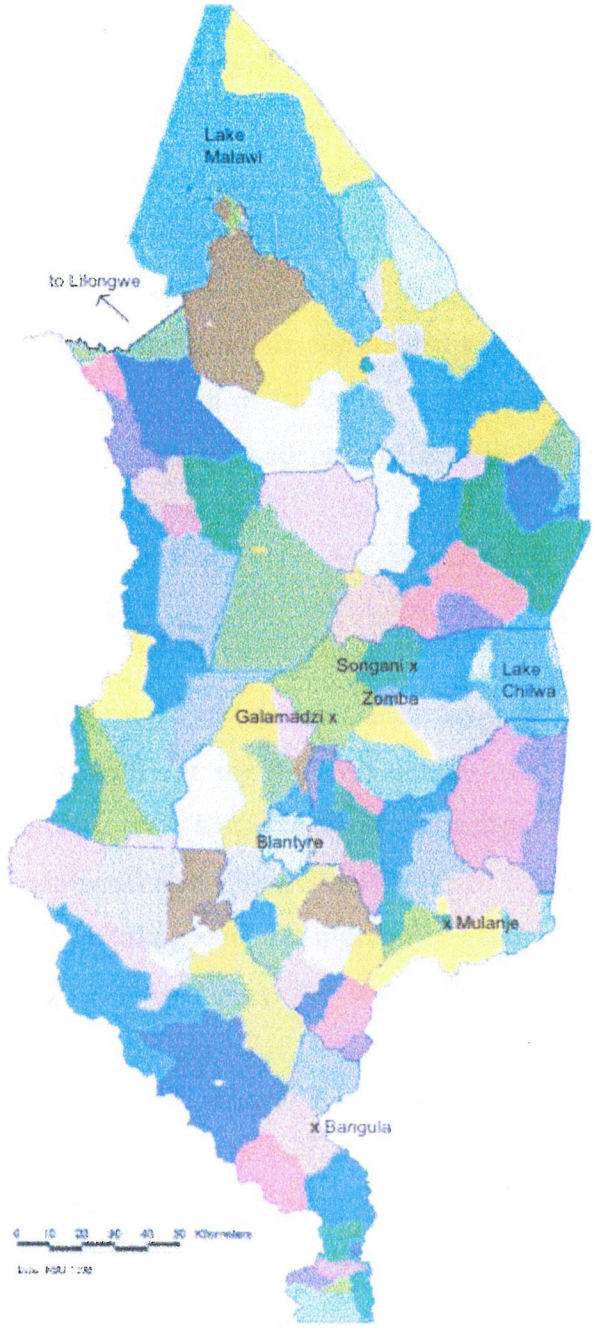
ABC	Abstinence, Behavioural change, and Condom use
ADB	African Development Bank
Admarc	Agricultural Development and Marketing Corporation
Aford	Alliance for Democracy
AIDS	Acquired Immune Deficiency Syndrome
AK	Authoritative Knowledge
AZT	Zidovudine
CABA	Children Affected by AIDS
CBO	Community-Based Organization
CSR	Centre for Social Research
DHO	District Health Officer
EAs	Enumeration Areas
EI	Emmanuel International
EU	European Union
HAART	Highly Active Antiretroviral Therapy
HDI	Human Development Index
HIV	Human Immuno-Deficiency Virus
IFAD	International Fund for Agricultural Development
IFI	International Financing Institution
IMF	International Monetary Fund
KCH	Kondanani Caring Hands (infant home)
LASG	Limbikani AIDS Support Group
MCP	Malawi Congress Party
MOH	Ministry of Health
MSC	Malawi School Certificate
NAC	Nyasaland African Congress
NFRA	National Food Reserve Agency
NGO	Non-governmental organization

NUD*IST	Non-numerical Unstructured Data: Indexing, Searching and Theorizing
OA	Open Arms (infant home)
OVC	Orphans and vulnerable children
PPH	Post-partum haemorrhage
ProCAARE	Program for the Collaboration Against AIDS and Related Epidemics
QECH	Queen Elizabeth Central Hospital, Blantyre
QMUC	Queen Margaret University College
RDC	Research Degrees Committee
RH	Reproductive health
RTIs	Reproductive tract infections
SADC	Southern African Development Community
SAP	Structural Adjustment Program
SOCCG	Songani Orphan and Community Care Group
SOS	Societas Socialis Children's Villages
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SWO	Social Welfare Officer
TA	Traditional Authority
TBA	Traditional birth attendant
UDF	United Democratic Front
UMCA	Universities Mission in Central Africa
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
ZCH	Zomba Central Hospital

FIGURE 1: MAP OF MALAWI

Source: http://www.cia.gov/cia/publications/factbook/geos/mi.html

FIGURE 2: TRADITIONAL AUTHORITIES OF SOUTHERN MALAWI



Source: http://www.nso.malawi.net/data_on_line/general/Atlas/Atlas.pdf/atlas_c_introduction_lowres.pdf

CHAPTER 1: INTRODUCTION

This thesis examines the impact of a mother's death on her kin and community, with particular emphasis on the care arrangements for orphaned children. In order to illustrate the complexity of the aftermath of maternal death, various aspects of Malawian culture are explored, particularly kinship, death and orphanhood.

This chapter explains the rationale for choosing the topic, and describes Malawi, highlighting relevant aspects of its culture and history. A report of the research methodology follows in the next chapter, before the thesis moves on to a discussion of fieldwork results.

Selection of topic

My concern with the topic of maternal death emerged through two main avenues: research in Guatemala for my MA on donor-led maternal mortality reduction initiatives; and work with Kosovar Albanian refugees in Macedonia (and later in Kosovo) on a Maternal and Child Health project. Both experiences convinced me that, despite overwhelming statistics highlighting the detrimental impact of maternal mortality, a lack of ethnographic portrayals of such contributes to an underestimation of their effect on society. Initially, therefore, I intended to fill this gap by writing a thesis that would provide a personal, even emotional, account of the consequences of maternal mortality.

Maternal mortality, however, seemed too narrow a cause of death to select, especially since I was also interested in the impact of HIV/AIDS on death rates. The category of 'sex-related maternal deaths' seemed more appropriate, since it includes those deaths strictly categorized as 'maternal mortality', as well as those related to HIV/AIDS. This, then, remained my choice of category until my arrival in Malawi, where I discovered that identifying the cause of death would be nearly impossible. Few individuals knew the actual cause of death of a mother, and it was generally of

little importance in comparison with the fact that a death had actually occurred. Maternal death, regardless of the cause, had a profound impact on surviving kin.

Malawi, as a research area, was easily selected. I had worked for the East and Southern Africa division of the International Fund for Agricultural Development before commencing my PhD and, therefore, was somewhat familiar with the region. My main criterion for selection, though, was that the country not be a war-zone, or have the potential to degenerate into one. Having worked in both Guatemala and Kosovo/Macedonia in near-conflict situations, it was time for a peaceful stint of fieldwork. Malawi seemed the least likely country to engage in conflict during my stay there and, despite being one of the poorest countries in the world, was described to me as being friendly and accommodating. That staff at the Centre for International Health Studies also had extensive experience with the country was also a factor in the decision.

Country description of Malawi

Malawi is a small, landlocked country in Central Africa (Figure 1), dominated by Lake Malawi, the third largest freshwater area in Africa. It has a population of 10.7 million, comprised of several ethnic groups. These are predominantly distributed regionally as follows: *Chewa* are found in the Central Region; the *Yao* are mostly along the lakeshore districts of the Central and Southern Regions, as well as larger urban areas such as Dedza, Machinga, Zomba, Blantyre and Chiradzulu; *Lomwe* are located mainly in the Shire Highlands, around the towns of Thyolo and Mulanje; and the *Nkhonde*, *Lambya*, *Tonga* and *Tumbuka* are found in the Northern Region. The ethnic groups in the north, and the *Sena* of Chikwawa and the *Nsanje* in the south, are patrilineal; otherwise the societies are matrilineal. This thesis is based on research in the Zomba area, predominantly involving Yao and Chewa (matrilineal) participants.

The country's economy is dominated by agriculture, and the majority of inhabitants are subsistence farmers. Until the 1980s, Malawi was self-sufficient in terms of food production. A combination of factors, including economic reforms in the 1990s,

falling demand for tobacco on the world market, the war in neighbouring Mozambique, and periods of drought, has meant that this is no longer the case. Overall, the economy is unhealthy, and other socioeconomic indicators also paint a grim picture. An overview of demographic indicators is provided in Table 1, along with other socioeconomic details.

TABLE 1: DEMOGRAPHIC AND SOCIOECONOMIC INDICATORS

Index	Census year		
	1977	1987	1998
Population	5 547 460	7 988 507	9 933 868
Intercensal growth rate	2.9	3.2	2.0
Density (population per sq km)	59	85	105
Urban population (%)	8.5	10.7	14
Women of child-bearing age as a percentage of female population	45.1	44.2	47.2
Sex ratio	93	94	96
Crude birth rate	48.3	41.2	37.9
Total fertility rate	7.6	7.4	6.2
Crude death rate	25.0	14.1	21.1
Infant mortality rate	165	159	121
Life expectancy:			
Male	39.2	41.4	40.0
Female	42.4	44.6	44.0

Source: Malawi Demographic and Health Survey, 2000: 2

The country is divided into three regions, Northern, Central and Southern, and into 27 administrative districts. Each district is divided into Traditional Authorities (TAs) that are either rural or urban, and which are presided over by chiefs. Rural TAs are divided into Enumeration Areas (EAs) which comprise, on average, 250 households. Urban TAs are divided into Wards, which are then further sub-divided into EAs. The average household size is 4.5 persons, and approximately 87% of the population is rural.

Research was carried out primarily in two areas, Songani and Galamadzi (see Figure 2). Songani is a settlement area located between Zomba and Malosa on the main road between Zomba and Lilongwe. Its market is located on this main road, and is well served by *matola* (pick-up trucks) and mini-buses. The local chief, Chief Nyani, presides over a number of villages, the inhabitants of which have relatively

easy access to several health centres, as well as to St Luke's Hospital in Malosa and Zomba Central Hospital (ZCH) in Zomba. There are a number of primary schools serving the area, and several, though fewer, secondary schools. The population is predominantly Yao and Chewa, both matrilineal societies.

Galamadzi is a village located in the TA of Mlumbe, The Village Headman is Bambo Ntoliro. It is located further away from Zomba than is Songani, on the road between Zomba and Changalume, which was constructed to serve the Portland Cement Factory at Changalume. There are very few mini-buses or *matola* on this road, hence, Galamadzi is less accessible than Songani. The TA covers several villages that are widespread and often separated by large hills; the terrain is very hilly and there is a significant problem with deforestation. Both the Songani and Galamadzi populations consist predominantly of subsistence farmers, though households also trade farm produce and/or carvings in order to supplement their incomes.

History of Malawi

David Livingstone and the missionaries

During the early 19th century, missionaries and traders followed in the footsteps of David Livingstone and started opening the interior of Africa to exploration and trade for Europeans. Livingstone's accounts of the slave trade in Central Africa in 1857 lead to the establishment of the Universities Mission in Central Africa (UMCA), which aimed to 'combat the slave trade by encouraging alternative commerce, to introduce the ideals of 'civilization', and to establish missions for promoting the spread of Christianity' (Else, 2000: 17).

Whether as a result of their association with the abolishment of the slave trade, or the advances in health care associated with early missionaries in Malawi (King and King, 1997), Christianity quickly became important in Malawi and remains a dominant force in everyday life. As is discussed further in later chapters, church

groups constitute a secondary social network to kinship, and provide significant aid with regard to funerals, orphans and vulnerable children.

Colonial era

The cessation of the slave trade, a reduction in inter-tribal conflicts and improved health status are still remembered by Malawians as positive British achievements. However, the seizure of lands by white farmers, the imposition of a 'hut tax' and the necessary migration from Malawi in search of work, soon resulted in anti-colonial feelings. In January 1915, John Chilembwe led the first attack on the colonial powers. Remembered as a national hero today, his uprising was unsuccessful, however, and he was executed at Mulanje, by the British. Following WWI, dissatisfaction with colonial rule increased among the African populace. When Nyasaland was joined to the Federation of Northern and Southern Rhodesia (now Zambia and Zimbabwe respectively) in 1953, growing disenchantment prompted the formation of the Nyasaland African Congress (NAC), lead by Dr Hastings Kamuzu Banda. Dr Banda had been living in exile since the 1920s – the reasons for which remain unclear. He originally worked on the gold mines in South Africa, where he came in contact with a group of American missionaries who paid for him to be trained as a medical doctor in Ohio. Subsequently he practiced medicine in Liverpool and then in Scotland where he became an elder of the Church of Scotland. Increasingly, he became involved with other nationalist Africans living in London, and moved to Ghana after forty years of living abroad. He was invited back to Malawi to lead the independence movement, and took over leadership of the NAC. After only a year as leader he had been so successful at mobilizing support that the colonial powers were forced to declare a state of emergency. The leaders of the NAC, including Banda, were imprisoned, and strict means of suppressing the independence movement were imposed.

Opposition to colonial rule continued to gain favour, however, and Banda was released in 1960. He resumed his position with the NAC, now re-named the Malawi Congress Party (MCP). At a constitutional conference in London in 1961 it was decided that Malawi would hold elections. Banda's MCP party swept to victory and

Malawi became independent in July 1964, with Banda as its Prime Minister. In 1966, Malawi became a republic, again with Banda as the head, this time as President.

The Banda era

Immediately upon becoming President, Banda began consolidating his position. He demanded that all ministers declare their allegiance to him. When some refused and attempted to oppose him, he drove them into exile. In 1971, he declared himself 'President for Life', and gained complete economic control of the country through the establishment of two companies: Press Holdings, his personal business, which owned the national supermarket chain, PTC; and the state Agricultural Development and Marketing Corporation (Admarc), to which all agricultural produce was sold at fixed rates. Along with these steps of dictatorship, he remained politically conservative. He encouraged Europeans to remain in managerial positions, maintaining that they were better suited to these roles than their African counterparts, and distanced himself from the other newly emerging African republics surrounding Malawi. Unlike his neighbours, he remained on good terms with the South African regime throughout his stay in power; allegiance which was rewarded with significant aid, trade and development assistance. Banda's regime remained politically oppressive. Many people who dared to oppose him were thrown into prison, and there was little observation of basic human rights.

Throughout his time in power, Banda encouraged Malawians to remain in rural areas and maintain their ties with their socio-cultural past. By promoting smallholder agriculture and discouraging migration to urban areas, he avoided the urban slums present in so many African countries, and, thus, also avoided the potential for those who opposed his rule to gather and ferment trouble in urban areas. This has had the long-term result that the majority of the Malawian population (roughly 87%) are rural dwellers. Their access to facilities and government-provided services, which are predominantly in urban areas, has therefore been limited, and is a significant factor in determining the nature of care that is provided to orphans. This is elaborated further in later chapters.

When, in 1977, the country held its first general election since independence, Banda personally vetted each candidate, demanding that they all be required to pass an English examination (thus eliminating 90% of the population). Even with these advantages, however, one Banda supporter lost his seat. He was simply reinstated by Banda. All members of society were expected to show total allegiance to 'His Excellency'; those who didn't were fired or, as in the case of three ministers in 1983, died under mysterious circumstances. The leader of the Socialist League of Malawi, an opposition movement based in Zimbabwe, was murdered. Also, one newspaper reported the death and disappearance of 250 000 people during the 30 years of Banda's rule.

Multiparty democracy

Throughout the 1980s and early 1990s there was growing internal opposition to Banda, as well as from the international community who were stressing the necessity of 'good governance' in order for countries to be eligible for financial assistance. It was the Roman Catholic Bishops, however, who were finally responsible for Banda's downfall. In 1992, they wrote a pastoral letter condemning Banda. This letter was read in every Catholic Church in the country, and was much publicized abroad. The international community ceased all humanitarian assistance to Malawi in response to this letter, stating that it would only resume once Banda had stepped down. A referendum on 14 June 1993 resulted in overwhelming support for multi-party democracy. The first multiparty elections were held on 17 May 1994. The main parties participating were the United Democratic Front (UDF), led by businessman Bakili Muluzi, the Alliance for Democracy (Aford) led by trade unionist Chakufwa Chihana, and Banda's MCP.

Voting in the election was primarily along ethnic and regional lines, since all parties had similar electoral agendas. The more-heavily populated Southern Region gave UDF victory, but without an overall majority. Though Muluzi attempted to form an alliance with Aford, this move was rejected and, instead, Aford and MCP formed an opposition coalition. Political prisons were closed down, and the prisoners freed; a free press was introduced and free primary education was provided throughout the

country. Economic reforms in the form of a Structural Adjustment Program (SAP), initiated by the World Bank and the International Monetary Fund (IMF) were introduced, and international aid was resumed.

The political situation remains murky, however. For instance, in 1994 Chihana was named second vice-president. The UDF hailed this as evidence of a political alliance between the UDF and Aford, however Chihana maintained that his party's coalition with MCP remained intact. Furthermore, there was no provision in the constitution for a second vice-president, an oversight that was soon corrected by an addendum to the constitution. By 1996, Malawi was experiencing intense economic hardship as a result of economic reforms. Workers' strikes became more common and there were reports of corruption among government ministers. Increased malnutrition was reported, linked to the eight-fold increase in the price of maize (the staple of the Malawian diet) between mid-1994 and mid-1996. The crime rate also rose.

Banda's death in November 1997, combined with the poor performance of the UDF, revived support for the MCP. A general election in May 1999, however, resulted in the UDF retaining power, despite an official opposition coalition of Aford and MCP. Accusations of vote rigging and news tampering were taken to the High Court of Malawi but were never resolved.

The next elections are due in 2004, at which point Muluzi would be required to step down after serving two terms as president. Over the past year, however, he has been making attempts to re-write the constitution to allow him to return. His initial attempt to change the constitution to allow a president an unlimited number of terms in office was defeated in a referendum in June 2002. Attempts are still being made, however, to allow him to return for a third term, a situation which has provoked much political debate, and which has contributed to Malawi's recent poor relations with donor countries. In December 2001, and for several months thereafter, protests were organized around the country in opposition to Muluzi seeking a third term, as well as to demand an explanation for government corruption. In Zomba, university students marched in protest on December 11, 2001, demanding an explanation for the

mysterious death of Evison Matafale on November 27 while in police custody. Mr Matafale was a musician who had published highly popular protest songs that were very critical of Muluzi and his government. When the students of Chancellor College marched, the police fired on them with live ammunition and two protesters were killed. The riot squad, using tear gas, was responsible for several other injuries. This provoked further protests and riots. In response, Muluzi unconstitutionally declared that mass gatherings would no longer be allowed and would be broken up immediately by the police. Several violent encounters occurred around the country, but the protests abated as the famine worsened and people spent more time focusing on procuring food for themselves and their families.

The southern African food crisis

Malawi is suffering from a severe food crisis, as are many of its neighbouring countries. After two years of poor harvests and food shortages, the current famine has reached a crisis point. Throughout 2001-2002 the maize harvest suffered from irregular rainfall and poorly performing maize crops. Alleged 'government mismanagement, corruption and bad advice from international donors' (Michael, 2002[1]) have also played a part. Poor governance was sufficiently an issue by the end of 2001 that Denmark suspended development assistance and withdrew its diplomatic envoys from Malawi:

> Danish Charge D'Affaires Finn Skadkaer Pedersen said 'a weak administration' in Malawi since 1995 has made it difficult to implement development programmes. ... He also said political intolerance by the ruling United Democratic Front (UDF) of President Bakili Muluzi as witnessed by politically motivated violence and what he termed as 'systematic intimidation of the opposition' has made it difficult for Denmark to continue assisting Malawi. (Tenthani, 2001[2])

Denmark's suspension of foreign aid to Malawi was soon followed by that of Britain, the European Union (EU) and the United States, all of which countries suspended

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[1] http://www.worldpress.org/Africa/703.cfm

[2] http://news.bbc.co.uk/1/hi/world/africa/1794730.stm

foreign aid to Malawi and cited concerns over 'widespread corruption and economic mismanagement'[3]. The EU also demanded reimbursement of funds that had already been disbursed. While evidence of government corruption and economic mismanagement were easily verified and justified a response on the part of international donors, the withdrawal of aid came at the worst possible time for Malawians. The country was at a point where it required foreign assistance to buy back previously exported maize stores to provide emergency rations to much of its populace. This fact was recognized belatedly by Muluzi, who declared a national state of emergency in February 2002.

Chronic policy mismanagement and corruption alone cannot, however, account for the current food crisis in Malawi. Allegations that the IMF are to blame for having given poor financial advice have gained support from international NGOs, most notably ActionAid and the World Development Movement. The Malawian government claims that it followed IMF guidelines to reduce farmers' dependence on government handouts, thereby restricting hybrid seed and fertilizer handouts. Many farmers too were unable to grow maize at all, due to the exhausted state of their soil. Furthermore, Aleke Banda, Muluzi's agriculture minister, claims that the IMF urged him in 2000 to sell portions of the country's grain reserve in order to finance the country's external debt. The National Food Reserve Agency (NFRA), however, sold the entire stock. It subsequently bought the surplus back from South Africa with an emergency US$30 million loan. ActionAid highlight the fact that food shortages were further exacerbated by profiteering by commercial food traders who hoarded grain until exorbitant prices allowed them to make massive profits (Devereux, 2002: 2).

Political climate relevance to the research process

The purpose of the above overview of the food crisis currently affecting Malawi is to highlight the main concern of the majority of people interviewed for this thesis. Most were struggling to feed their families. This affected the research environment and,

[3] http://news.bbc.co.uk/1/hi/world/africa/1665141.stm

possibly, the nature of some of the answers to questions. One of the things that I was interested in investigating was how households defined the difficulties surrounding the death of a mother within a family. That the answers to this question routinely focused on the lack of food for orphans was probably biased to some extent by this latest food crisis. I qualify this supposition because, for many of the participants in this study, access to food has always been a struggle, so this may have been their response in any case, even when food was not in as short supply as it was at the time of the study. Determining the extent to which the famine affected the perceived problems of families coping with the death of a woman and the subsequent incorporation of her children into the extended family was outside the scope of this investigation. The possibility of such a bias is raised here, however, and will be discussed later in further detail.

Moreover, the fact that Malawi was undergoing food shortages throughout the period of my fieldwork affected my relationship with my research communities, and the way in which I interacted with them. This issue is further elaborated upon in Chapter 2.

The aforementioned political machinations surrounding the food crisis and the third-term constitutional amendment are presented here because they are also indicative of a more generalized problem. Corruption and poor governance do not affect the food supply in isolation; all aspects of social life in Malawi feel the effects of government corruption. This is important within the context of this thesis since orphan care is also affected by the shambles in national governance. Throughout the country, government programmes aimed at supporting orphans are affected, and the situation must be understood in order for the difficulties of implementing such programmes to be fully explained.

Theoretical framework

This thesis analyses the impact a mother's death has on her family and her community, and concludes that this effect is disastrous for all involved. The most obvious consequences of maternal death include increased child mortality,

impoverishment of the extended family, and reduced educational attendance of orphans. Less obvious, though potentially more devastating, are the beginnings of breakdowns in traditional socio-cultural structures, and the mental health consequences of orphanhood and abridged mourning periods. While the specific ramifications of a mother's death are devastating to any family, that these deaths are occurring with increased frequency due to the HIV/AIDS epidemic, means that their effects are not limited to the extended family or community. Rather, the impact of a mother's death has ramifications for the whole of Malawi and, to the extent that other sub-Saharan countries are experiencing a similar phenomenon, for the region surrounding Malawi. Included in this thesis is a portrayal of the coping mechanisms used by families, together with an analysis of how such mechanisms may be supported by outsiders (such as the Malawian Government and international donor agencies) while they are still relatively intact. Despite the overwhelming nature of the disaster of a mother's death, and that the cumulative impact of repeated deaths has not yet been felt, families and individuals are currently functioning to the best of their abilities. How much longer this will remain true is difficult to predict, but it is certain that, without assistance, these coping mechanisms will be overwhelmed beyond the point of survival.

I maintain that these events have the potential to severely undermine the Malawian social structure and, in order to highlight this, the thesis also situates such deaths within a national framework. Crucially, this thesis concludes that culturally sensitive interventions *now* may avert the full-scale social destruction that will otherwise occur. Malawian culture has proved to be resilient, and has evolved coping mechanisms that have ensured the survival of community members through periods of intense poverty and natural disasters. These same coping mechanisms have also proven effective in the face of the current epidemic of HIV/AIDS and associated maternal deaths, but the extent of the current disaster is unprecedented, and the full effect has not yet been realized. Support of existing coping mechanisms presents the most effective solution for providing care to the increased numbers of orphans in Malawi.

The primary objective of this thesis is to discuss the impact and responses of individuals to the loss of a mother. This portrayal is *personal* to the individuals who are affected by this loss. The heartbreak, struggles and tremendous courage evidenced by every single person who shared their lives and stories with me cannot be over-emphasized. Using data gathered from interviews and participant observation, case studies of the coping mechanisms used by individuals are presented throughout. While these stories are all particular to the individual involved, they are by no means unique. It is the very repetition of such stories at a country-wide level that presents the greatest challenge to the social structure.

My analysis of the impact that a mother's death has on kin, community and country drew on a number of key concepts. These are introduced below, as is the rationale for including them and an indication of the part they play in meeting the research objective.

Kinship

In Chapter 3, an analysis of the nature and role of the family is provided. Kinship, in many societies, *is* society, but what exactly constitutes kinship varies between cultures. In order to understand the impact that a mother's death has on her family, it is first necessary to understand how the individuals in the research area define 'family'. To address this question, people were asked to explain their understanding of the concepts of 'mother', 'father', 'family', 'community' and 'orphan'. Further questions were asked about the expected roles and responsibilities of family members, and ways in which relatedness between family members is demonstrated. These responses provide an indication of the way in which such terms are used emically and to facilitate an outsider's understanding of the local folk models in use.

The communities under study are predominantly of Yao and Chewa ethnic origin, and the kinship patterns and gender relations prominent in these cultures are described. Furthermore, the discussion of kinship is positioned within an anthropological framework. In the context presented in this thesis, Malawians recognize the biological basis of kinship in a similar way to our European

understanding of such ties. This is not, however, the sole basis for kinship. Kinship is also defined by 'care' and 'provision', and is a tie that can lapse and be renewed. It is also processual in that orphans and their caregivers become closer as the process of 'forgetting' the dead mother takes place.

An important aspect of kinship also discussed is that of sibling pairing. These have profound ramifications for adult patterns of responsibility and residence. Crucially, they impact on decisions regarding the identity of the prime caregiver for orphaned children.

HIV/AIDS

Following the analysis of kinship in Chapter 3, Chapter 4 presents a discussion of HIV/AIDS in Malawi. This disease is a horrifyingly significant factor in Africa, and any discussion of culture and society cannot ignore its existence. An examination of the HIV/AIDS epidemic within the Malawian context is provided, and the disease is linked to increased rates of maternal death and the associated increase in the number of orphans and vulnerable children (OVCs).

The differential way in which the virus affects age groups and the two sexes is explained, together with an analysis of the social ramifications – in particular as they apply to women. HIV/AIDS is highlighted not necessarily because it is more lethal than other diseases, but rather because it plays a key role in accelerating the social decline associated with increased numbers of orphans and the impoverishment of families providing care to these orphans. This chapter prefaces a subsequent discussion of death. A preliminary discussion of the scale of the HIV/AIDS epidemic in Malawi contextualizes the escalation of deaths (Chapter 5), and the associated curtailment in funeral rituals and mourning period.

Death

Maternal death has a profound impact not only on the family unit but also on the community as a whole. The loss of a caregiver affects a child's survival potential,

and the community is deprived of a productive labourer and social carer. Based on an understanding of the mother-child relationship, this document analyses the impact that maternal death has on the deceased's family and community. Integral to this relationship are local beliefs about what constitutes 'parenting', a discussion that builds on information presented previously (Chapter 3). Insofar as maternal deaths are often linked to infant mortality, some analysis is also provided on how the family unit and the wider community rationalize and explain infant death. Theories of death and associated rituals play a central part in this analysis.

The study of death within the context of this thesis is used to highlight the specific impact of the death of an adult female on family structures. Sadly, death and funerals are increasingly becoming a fact of everyday life in Malawi. This is in large part due to the impact of HIV/AIDS on the population, an issue that is discussed in depth in Chapter 4. Crucially, this increase in the frequency of funerals has also undermined the efficacy of traditional mourning rituals in healing the wound in the community inflicted by the death of one of its members.

Orphan care

The inevitable consequence of a mother's death is the orphaning of children. How families care for such children is a key coping mechanism that is analysed in Chapters 6 and 7. The increased number of orphans is largely responsible for the impoverishment of communities, and is undermining traditional social structures. Various responses in caring for orphans are presented in Chapter 6, as is an analysis of the merits and faults of each approach. Chapter 7 situates the issues of OVCs within a national framework, and discusses the policy-level responses to the crisis. Recommendations for improving initiatives aimed at assisting communities in their struggles to care for orphans are also provided in this chapter. In both chapters, the point is made again that timely, sensitive initiatives are required in order to prevent further, and possibly irredeemable, destruction of communities.

Functionalism and Authoritative Knowledge

A number of themes are examined in order to fully expound the impact of a mother's death on her family and community; in particular how the extended family copes with looking after the resultant orphans. Throughout, the analysis borrows from the theoretical literature on functionalism and the idea of 'authoritative knowledge' (AK). The starting point of functionalism is that all societies (families) have certain basic needs – functional requirements that must be met if a society (family) is to survive. Humans, therefore, operate in ways that enable society or, in this instance, the institution of the family to continue. Those needs within the Malawian context are defined here along with explanations of how various families have attempted to meet these requirements in order to cope with the strains being placed on the nature of the family.

The concept of AK has been articulated by Brigitte Jordan (1997) primarily in order to explore the rationale behind the medical world's under-estimation of the work of midwives. Commonly, doctors express highly emotional indictments of midwives and the idea of home birth that are not necessarily backed up by epidemiological, clinical and/or rational data. As a tool of analysis, however, AK is more widely applicable outside of the context of childbirth (see Chapter 7).

The role of external experts in the arena of orphan care is examined using the concept of AK to elucidate the way in which certain practices have become official policy. This process is compared with that of colonialism, particularly as expressed through health and development projects in modern times. Chapter 7 examines how AK is established within the specific context of orphan care in Malawi.

Conclusion: Contribution to theory

This thesis will fill a gap in the literature surrounding AIDS-related maternal deaths, and concomitant orphans, in sub-Saharan Africa. It provides an in-depth, case-study portrayal of the impact of these two phenomena on several communities in Malawi. Furthermore, it highlights the specific effect of a mother's (as opposed to another family member's) death on her family and community. The specific coping strategies

adopted by those affected by her death are of interest insofar as, worldwide, high levels of maternal deaths have been shown to have a profound impact on families, communities and surviving children. UNAIDS has pointed out that while data on the macroeconomic impact of HIV/AIDS in Malawi is extensive, particularly in comparison to that for other sub-Saharan countries, 'no data are available on the impact of AIDS at the household level' (2000*a*: 132). This study specifically addresses this statement insofar as a large percentage of maternal deaths are linked to the disease.

The thesis also contributes to a study of gender relations in Malawi, highlighting the specific ramifications of a mother's death, while the analysis of the role of development organizations in caring for orphans and vulnerable children (OVCs) contributes to the literature on development studies

Finally, the presentation of sibling pairs as a key element of kinship is also a contribution to African kinship literature. By demonstrating that such pairs are a crucial factor in the coping mechanisms to the growing orphan crisis, this thesis links an innovative analysis of kinship with a positive portrayal of kin responses to maternal deaths.

CHAPTER 2: METHODOLOGY

Research access

Prior to leaving for Malawi I had been in contact with the Centre for Social Research (CSR) and had requested information about the process of applying for clearance to carry out research in Malawi. I was notified to submit two copies of my proposal (the same proposal previously submitted to the Research Degrees Committee (RDC) at Queen Margaret University College (QMUC)), two passport-sized photographs, and to pay an affiliation fee of US$500. It was agreed that the photographs and cheque could be submitted on arrival in Malawi. Email communication was very infrequent, and it took several months before I was told that I had received research clearance, and that I should proceed to Malawi to carry out my fieldwork. The written confirmation of this clearance arrived by post two days before I left Edinburgh. After receiving the email confirmation, I enquired as to whether there was anything further to be done, to which question I received a reply from the Assistant Director of CSR stating that I had fulfilled all the requirements for research clearance. I proceeded with booking airline travel.

Upon arrival in Malawi I had to remain in Blantyre for a week due to the fact that the airline had lost my luggage and, once found, would not deliver it to Zomba. During that time I made contact with Open Arms Infant Home (OA) and requested permission from the managers to do some fieldwork there – interviewing caregivers and, where possible, the families of orphans currently in the home. This permission was granted with the provisos that interview questions be sanctioned by one of the managers before being used, and that a copy of the final thesis be provided upon completion. I spent much of this first week in OA, getting to know the staff and helping to look after the forty-two orphans who were then in residence. The following week I proceeded to Zomba and met with the Director and Assistant Director of CSR. My priority was to find housing for the term, a process that took

some time. Meanwhile, I stayed in a hotel and got to know my way around Zomba, and I introduced myself to staff at CSR.

CSR is part of the University of Malawi though it generally operates quite separately from Chancellor College, where classes take place. It is an institution that conducts social science research in partnership with both the public and private sectors and was established in 1979 with support from UNICEF. While it is a Department in the Faculty of Social Science at Chancellor College it is autonomous and employs its own staff. Staff salaries, though, are funded through a Government subvention to the University. CSR functions primarily as a consultancy firm. For the most part, staff members are protective of their ongoing research projects. They are somewhat reluctant, therefore, to discuss research questions and issues with visiting researchers. When I was constructing my interview schedules, however, one staff member in particular, Dr Brenda Gallagher, was very supportive and shared with me her expertise in developing questionnaires. I was also fortunate to be doing my research at the same time as three Fulbright scholars from the US. One of these was a professor in political science, Dr Beverly Hawk, who lectured at Chancellor College; another, Dorothy Overpeck, was a PhD student studying sustainable agriculture; and the third, Ana Weil, was doing a research project on self-medication for malaria. These three individuals, along with a professor of chemistry at Chancellor College, Dr Elizabeth Henry, were invaluable in providing research support.

At the beginning of July, having found a house and started Chichewa lessons, I made contact with the District Health Officer (DHO) at Zomba Central Hospital (ZCH). It was at that point that I discovered that I had not been informed by CSR of the full process of requesting research clearance, and had still to make an application to the National Research Committee of Health and Science. Without this clearance I was unable to identify case studies through the central hospital records, though I was free to conduct research in Malawi using non-government-related sources. Since the committee only met twice per year, and the next meeting was in September, I changed my planned means of case-study identification. I had been introduced to a former AIDS-counsellor from St. Luke's Hospital in Malosa (near Songani) who had resigned from his position in the hospital to start a community-based orphan-care

project in Songani. This Mr Kennedy Mpoya had been operating the Songani Orphan and Community Care Group (SOCCG) for approximately six years. The history and nature of this group is described in detail in Chapter 6.

I met with Mr Mpoya and the other volunteers who help run the project to explain what I was researching and requested permission to do some interviews in their communities. Permission was granted, conditional to them choosing the interviewees. Fetterman (1998) recommends a wide-net approach to initial sampling, using integral and powerful members of a community as entry. He points out, however, that it is also important to establish yourself as an independent entity to avoid being identified too closely with these same individuals. The main constraint to establishing my independence was my lack of knowledge of the Chichewa language, however, and so I set about finding a translator/research assistant. This process took considerable effort but, finally, I found a young woman, Fadi Nyerenda, to help. At the same time as I was engaged in looking for a translator, I was also looking for a car to buy since I realized that physical access to research sites would be impossible without my own transportation. By September, I had both a car and a translator and was conducting research in Songani. Initially, I was accompanied to interviews by Mr Mpoya, who insisted on doing so to 'show me the way' and introduce me. This was very useful when meeting families for the first time, since there are few roads in that area, and those that are there, are un-signposted. Once in a village there is the added problem that the houses are very spread out and, initially, looked very alike. Navigating through maize fields using natural landmarks requires some practice after living in an urban environment, and so Mr Mpoya's and Fadi's help was required often. Once Mr Mpoya was sure that I could find my own way, Fadi's support was sufficient on subsequent visits. I soon began to note landmarks and became capable of locating houses by myself.

By December, I was ready to start including some case studies from other areas around Zomba, to expand on the data already being collected from Songani. At this point a trader who regularly visited CSR, Philip Tambala, mentioned that his sister had died and he was looking after her children. I spoke to him about my research and he agreed to be interviewed. After the first interview he asked if I would be

interested in interviewing other people in his community, since there were many more like him who were looking after orphaned children. I subsequently hired him as a second research assistant and he became responsible for locating case studies for me in Mlumbe Traditional Authority (TA).

My intention had been to include in my research case studies of families who had left their children at Open Arms Infant Home. I had a list of such families from OA, but this indicated simply the names of the next of kin and the village or TA in which they lived. From January 2002 onwards, I attempted to find these individuals, but with very little success. They were spread over a wide geographical area and, due to the fact that it was the rainy season and many villages were not located on roads at all, physical access was a significant issue. The Social Welfare Officer (SWO) in Zomba was unable to help me locate these families because some of the fathers who had originally placed their children in OA had either subsequently died or had left the area to find work. Furthermore, with no transportation of his own the SWO was unable to follow up on any of these case studies so had not had contact with them since receiving the orphans into his care. After many fruitless journeys to far-flung villages, and with only one successful interview to show for the effort, I went instead with my research assistant to OA in Blantyre on the weekends and we interviewed those family members who visited the orphaned children. These trips could not be made very often and so interviews with families of children in OA are relatively few compared with the number of families with orphaned children at home in the villages. The reality does, however, reflect the proportion of Malawians who care for orphans within the family and within their own village, compared with those who rely on urban-based institutions.

Development of research tools

Throughout July and August, I shared my research proposal with two members of staff at CSR, Nakatiwa Mulikita and Brenda Gallagher, as well as with several other researchers and a doctor from Zomba Central Hospital (ZCH). From their comments, it was generally agreed that focusing on female deaths primarily from AIDS would be impossible due to both the generally poor record keeping in the hospital and the

stigma attached to dying of AIDS. Because of this stigma, people are seldom identified publicly as having been HIV positive, particularly not on the few death certificates that are issued. It would be extremely difficult, therefore, to identify AIDS-related deaths. Thus the focus was widened to all causes of death in mothers. Insofar as HIV/AIDS is one of the leading causes of death, and is clearly associated with the increased number of OVCs in sub-Saharan Africa in general, it remained as a topic within my research agenda. My selection criteria for case studies were necessarily re-defined as 'a women who has died within the past year, and who has been survived by children of school age'. I purposely did not specify whether or not these children had a father living, since I was interested in comparing the fate of children who still have fathers versus those who have lost both parents.

While people were commenting on my proposal, I wrote a list of questions to be asked in my first interviews with case-study participants. These were further developed in conjunction with Brenda Gallagher and Fadi Nyerenda. Fadi translated them into Chichewa, and then back again into English, and we went through them to ensure that the original meaning had not been lost. For additional confirmation of accuracy, the Chichewa questions were also compared with the original English version, by two friends. Chichewa does not have the complexity of English, and asking open-ended questions is rather difficult, as are neutral questions. For instance, there is no neutral term for 'emotions' in Chichewa – it is necessary to ask whether the person feels happy/sad/or otherwise. Simply asking 'how do you feel about' something, is useless. The English and Chichewa versions of interview scripts are included as Appendices 1 and 2 respectively.

Several members of staff at CSR confirmed also that it would be detrimental to building a relationship with case-study families if I were to ask them for written consent prior to conducting the interview. Very few of the people I interviewed had received any education. Of those who had attended school, this would only have been to primary level and would be insufficient for them to grasp the meaning behind a consent form. In a culture which is primarily oral, and in which the only forms to which people are exposed are associated with government officials, presenting someone with a written consent form could become entangled in a history of

people's previous, often negative, experiences with written communications (e.g. Buseh *et al.,* 2002: 176). It also further emphasizes their powerlessness within the official sphere, a fact with which they are confronted almost daily when negotiating with funeral homes and hospital personnel. I therefore developed a standard explanation for my research and discussed this with the interviewees prior to the first interview. Written copies of the explanation were left with various people in the communities in which I was conducting fieldwork: Mr Mpoya in Songani, Philip Tambala and a school teacher in Galamadzi, and volunteers at the Limbikani AIDS Support Group in Malosa. This information was provided to each interviewee on an individual basis prior to the first interview, during a general introductory chat.

On returning to various homes in Galamadzi, however, after I had been doing research in the area for several weeks, it came to my attention that there was a rumour going around about my research objectives. Every time I left a village for the return trip to Zomba, I would pick up hitchhikers. The vast majority of these required transportation to ZCH (a good forty minute drive away and obviously longer on foot) to visit sick, perhaps dying, relatives. From this, people deduced that my research was actually about transportation options to and from hospital. Though I discussed my research role in depth to ensure that my research assistants had a clear picture of what I was looking for, and could explain this to my interviewees, I also visited the village chief to clear up the matter. Though very little discussion took place at the meeting, I was reassured by Philip and Fadi, both present at the time, that the problem had been taken care of and that there would be no future misunderstandings about my research goals.

Each interview was preceded by a period of 'chatting' (*kuchala*), during which I introduced Fadi and myself. At this point I would also offer to obscure their identity in my final report by giving them a pseudonym and changing any identifiable characteristics. This offer was always declined, but I have changed the names of some informants nonetheless. People whom I knew to be easily identifiable, and who shared intimate details with me which weren't of common knowledge, have been given pseudonyms. With those informants whose names I have not changed, I have

referred to them by only a single name. Some individuals remain easily identifiable, a conscious decision since they will have access to the completed thesis, and would be pleased to see their names in print.

We then talked about the family and their maize garden, and the interview would begin. Before turning on the tape recorder I always asked for permission to tape the interview, and then repeated the question once the tape had been turned on. After receiving lots of impatient replies to the effect that they had already said yes, I subsequently asked permission only as I turned on the tape recorder. Had the reply been negative I would have turned off the tape recorder immediately, but this situation never arose. Most people enjoyed hearing some of the interview being played back at the end. It provoked much laughter and enjoyment, and so became part of the interview process; at the end of any interview I would let them hear the last few minutes. A short time before I left Malawi, Philip suggested that many people would like to have copies of their interviews. I obliged by making and distributing such to the relevant families. Since none of my case-study participants would understand a written copy of my thesis, and none expressed any interest in having a taped and translated version provided to them upon completion of my thesis, this is the closest that they will get to tangible feedback of my results. Prior to leaving the country, I met with many of my interviewees and discussed my research with them one final time. However, because I was leaving during a period of extreme hunger and many family members had moved away temporarily to places where they could either find employment or stay with better-off relatives, my leave taking from the field was not accomplished with all of the people with whom I had made contact.

I did the first few taped interview transcriptions together with my research assistant. After we had gone through several interviews together, though, Fadi (and later, Doreen, who took over from her) would do the transcriptions herself. Since the interviews were in Chichewa, having Fadi do the transcriptions by herself took less time. I would then type up the written transcriptions, which she would translate into English; the translation was then typed out. Due to problems such as dirt in the tape recorder and the general difficulty in obtaining batteries and blank tapes, we were

unable to record some interviews. In these instances, Fadi and I would both make notes throughout the interview and then compile a summary of the interview upon our return to Zomba. The majority of interviews were taped successfully, however, and the tapes are still in my possession.

Follow-up interview questions were less structured. Queries that arose from the initial interview were noted, as were general questions that occurred to me in the interim. After these had been translated into Chichewa, and back again into English, they were put to the Songani-area case studies. At the time of doing the follow-up interviews in this area, I was commencing the initial round of interviewing in Galamadzi. Doing both stages at the same time allowed me to refine the follow-up questions further. Thus, the follow-up interviews conducted with Galamadzi residents are more uniform.

I supplemented case-study interviews with questions directed at more general audiences, i.e. individuals who were in positions whereby they could provide some form of social commentary. I questioned some schoolteachers, hospital workers, orphanage personnel and domestic workers about the impact of maternal deaths on communities and the subsequent increase in the number of orphans in the care of extended families. Furthermore, since the HIV epidemic is so crucial to an understanding of the increased number of orphans, I also met with members of an AIDS support group and interviewed them to inquire about their experiences of living with AIDS. Both Mr Mpoya, formerly an AIDS counsellor, and Dr Jay of the ZCH commented on the content of these questions prior to them being presented.

At the beginning of each interview I explained to the interviewee that I could change their name and other details about their character in order to make them unrecognizable. In every single instance I was told that this would be unnecessary. In two instances of HIV-positive people, however, I was asked not to interview them in the presence of their neighbours or family, since their status was not common knowledge. Though they had refused the possibility of being made anonymous in my research, I felt that their fear of being identified by their community as HIV positive

was sufficient reason to mask their identities in the written report. I have, therefore, assigned arbitrary names to all of the HIV-positive people that I interviewed from the Limbikani AIDS Support Group, but have kept the names of the villagers I interviewed in Songani and Galamadzi. Since my presence in these last two communities was regular and sustained, not to mention highly noticeable, it was widely known who had and had not been interviewed, and anonymity could not have been maintained.

A table providing an indication of the number of interviews conducted, age of interviewees, as well as the extent of contact with each respondent is provided in Appendix 4.

Theoretical issues of the methodology

For the purpose of this thesis, grounded theory was used to investigate the impact of a mother's death on her surviving family and community. Based on American pragmatism and symbolic interactionism, grounded theory has been developed over the past thirty years primarily by the sociologists Barney Glaser and Anselm Strauss. Haig (1995) stated that this method is particularly relevant for qualitative research, since it 'is portrayed as a problem-solving endeavour concerned with understanding action from the perspective of the human agent'[4]. This definition resonates with the intent of this research, namely to understand the mechanisms by which communities cope with the care of orphans who are left by the death of their mother. Haig elaborates on the procedure as follows:

> Grounded theory research begins by focusing on an area of study and gathers data from a variety of sources, including interviews and field observations. Once gathered, the data are analyzed using coding and theoretical sampling procedures. When this is done, theories are generated, with the help of interpretive procedures, before being finally written up and presented. This latter activity Glaser and Strauss claim is an integral part of the research process. (ibid.)

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[4] http://www.ed.uiuc.edu/EPS/PES-yearbook/95_docs/haig.html

This approach was particularly relevant here since my aim was to create an anthropological account of the social phenomenon in Malawi of orphaned children, and the associated community response. Understanding of this issue, along with an elaboration of the coping mechanisms used by these communities, evolved from a combination of interviews, participant observation and literary research. These mechanisms enabled the communities themselves to guide the outcome of the research, and the observations included in this account are led, therefore, by the realities of participants' lives. Furthermore, using a combination of data-gathering techniques enabled me to create a detailed account of the daily lives of orphaned children and their caregivers, thus presenting a richer image than had I only relied on one means of data gathering.

In order to avoid being blinded towards potential solutions created by communities themselves, I felt it important that I not enter the field with too rigid a model of coping mechanisms in mind. My deductions regarding the solutions employed by communities to handle the increasing number of orphans in their midst, as outlined in this document (particularly in Chapters 3 and 6), arise directly from observations and investigations within these communities gained through the combination of techniques described above. Participant observation is one means by which such community-led answers emerge. It requires immersion into the culture being studied, usually through long-term residency, and allows the researcher to understand people's fears, beliefs and behaviours from within the context of their own culture. A technique commonly used in anthropological investigations, it provides a rich qualitative description of a culture or aspects thereof.

Fetterman's (1998) guidelines on interview content and conduct were used in preparing for the interviews. In brief, these include an analysis of the types of questions to be included, such as those concerning participant background (demographic questions), experience, behaviour, activities, their opinions and values, and knowledge of particular issues. He points out also the importance of preparing for an interview by understanding the level of formality required, acceptable attire, and the importance of not imposing one's own version of a response on the

interviewee, as well as carefully selecting the location for the meeting. In Malawi, I was required to wear a *chitenje*, the traditional piece of cloth wrapped as a skirt, whenever I was in a village. I chose to conduct interviews at the homes of all respondents, since transportation would otherwise be a problem that would also require them leaving their agricultural activities for longer periods. On arrival at someone's house, a child would usually call the people to be interviewed in from the field, and after the usual period of greetings we would sit down together. At first I was always offered a chair, while everyone else would sit on a mat on the floor. When, at the first visit to each place, I indicated that I preferred to sit with them, my response was greeted with laughter and appreciation. Thereafter, it was always assumed that I would sit on the mat with them to conduct conversations and/or interviews. Scheduled meetings with official personnel are generally quite elaborate affairs in Malawi but interviews conducted in a rural setting with people in their own homes were engaged in simply as periods of *kuchala*, a general term which encompasses interviews, social events and gossiping between friends. Interviews, therefore, were conducted in a general atmosphere of informality, which contributed to people being comfortable enough to answer questions that were often of a personal or potentially threatening nature (HIV in particular, and pregnancy in some situations, is seldom discussed in public).

The interviews were semi-structured, i.e. I had a schedule to follow. However, I would also ask incidental questions not included in the original schedule if an answer was particularly interesting, elicited more queries, or required further elaboration. This allowed me the flexibility of getting comparable answers, while also allowing the respondent to direct the course of the conversation within the interview context. It happened that many responses, when translated during the course of the interview, were not followed up on immediately. Also, in some instances the immediate translation differed slightly from that offered after transcription giving rise to further uncertainties. In order to provide opportunity to elaborate on any unclear points, follow-up interviews were scheduled at the time of the first interview.

Relevance of method to objective

I anticipated that a combination of methods of data collection would be best suited to presenting the varied picture necessary to depict a full qualitative account of the ramifications of a mother's death. Therefore, I employed methods of participant observation, semi-structured interviews, and literary research. Each of these had specific benefits and demonstrated diverse aspects of the topic under investigation.
Participant observation allowed me to gain an awareness of the everyday lives of people looking after orphans, outside of an interview context. This presented observations on matters that might not necessarily have occurred to me to investigate, as well as being a means of data collection in situations in which questioning would not be acceptable, such as during funerals. Furthermore, it served to establish a relationship with case-study families that would not have been as deep had I restricted my contact solely to interview contexts.

Semi-structured interviews provided me with the opportunity to gain some comparable data across a variety of families dealing with the task of orphan care, and gave an indication of how prevalent were certain attitudes and beliefs. Furthermore, interviews allowed me to ask questions which would not normally be appropriate in everyday conversation and, because of the artificial nature of the interview setting, these questions (and the obvious ignorance that led to them being posed) were more acceptable.

CSR maintains a document centre housing copies of many publications authored by staff and visiting researchers. It is the best source of Malawi-related health and social research that I have encountered. This library was particularly useful when I first arrived in Zomba and was still acclimatising. I used it extensively to seek guidance for interview questions and it provided a lot of background reading, as well as many publications on the political and legal contexts of orphan care. It was an invaluable aid to my research. This research of the literature, along with literature reviews carried out before leaving for the field, and complemented by fieldwork, combined to present as full a picture as possible of the events under investigation.

Relationship with research assistants

As soon as possible, I hired as a research assistant a young woman, Fadi Nyerenda. She had completed secondary school – the Malawi School Certificate (MSC) - and was waiting for her results before deciding what career to follow. She is a Tumbuka (from the North of Malawi) but lives in Zomba with her older brother, a student at Chancellor College. Fadi is extremely proficient in English, as well as being very organized and open to new experiences (such as learning how to use a computer and how to type). She was responsible for the first translation of my interview questions, and discussed this with her brother Joseph and myself to make sure that the sense of the questions was translated as accurately as possible.

Importantly for me, Fadi's brother is married to an expatriate and she therefore understood many of the problems that they face in villages. She was a very good guide for me when I first started making visits to villages. Her experience in guiding novices through social situations that could prove awkward without cultural familiarity was invaluable to my research, above and beyond simply acting as a translator/transcriber. I was also fortunate in that her family was supporting her financially, and the money she earned from me was simply a contribution to living expenses, rather than a strict requirement. She was being encouraged by her family to save as much of her wages as possible for use while at university, and it was agreed that I would teach her how to type and use a computer as part of her remuneration. I also gave her a computer of her own that she kept after her term of employment with me ended.

Unfortunately, Fadi did not do as well as she had hoped in her MSC exams. In April 2002, therefore, she made the decision to go back to school for the rest of the year and re-sit her exams in November in the hopes of getting better grades and being able to go to Nursing College. This necessitated me having to find someone else as a translator. Since I had had extreme difficulties finding Fadi in the first place I was not eager to start the whole interviewing process again. It happened, though, that one of the Fulbright scholars, Dorothy Overpeck, was returning to the US, and her research assistant, Doreen, agreed to help me out. She was translating part-time for

Ana Weil, but this was insufficient to meet her living expenses, especially since she had recently given birth and was now responsible for herself, her unemployed husband and a young child. Ana and I, therefore, coordinated our schedules so that Doreen could spend half of every week with each of us. She was effectively working six days per week.

Doreen had also completed her MSC, and had left school aged nineteen to get married. Her daughter, Dorothy, was born in January 2002 and accompanied us during most of our fieldwork. The fact that Doreen was the main wage earner in her family meant that she was highly motivated and very eager to do as much work as possible. It presented problems, however, in that she was financially dependent on her employers, and with the growing food crisis in the region she was constantly asking for loans. Ana and I both felt that we had more of a parental relationship with Doreen than we had had with Fadi, in that she assumed that we would feel responsible for her and her daughter. This was true, to a certain extent, and made leaving the field very difficult. Since both Ana and I completed our research within a month of each other and subsequently left Malawi, we worried for Doreen's future. She was given two month's severance pay by each of us, along with letters of recommendation for future jobs. At the time of writing this, however, she has still been unable to find employment.

Relationship with research communities

My relationship with the communities in which I conducted research is difficult to characterize in a straightforward manner. Many inhabitants of the villages in which I was working assumed that I was there as a precursor to a development project and, despite my attempts to clarify that this was not the case, I fear that there may still be those who feel cheated due to the fact that no project has materialized subsequent to my research. My presence there was further politicized in that being interviewed by the *mzungu* (white person/foreigner) was considered to be a mark of status. The selection of case-study families accomplished by Mr Mpoya and Philip Tambala in Songani and Galamadzi respectively, was probably done with this in mind. This is especially true since the issue of rewards for being interviewed was constantly

present. I dealt with this matter differently for each of the communities, for reasons discussed below.

Before commencing interviews within the Songani community, I had agreed with Mr Mpoya that instead of rewarding the individual families I interviewed, which would be only a small fraction of the total number of families served by the community centre, I would make a donation to the community centre itself. It was agreed, therefore, that I would buy 100 kg of maize to be distributed at one of the fortnightly distributions, two 25 kg bales of clothes, and that I would also contribute to the school fees fund, donating the equivalent amount of sending two children to secondary school for a year (primary school is free for all). In collaboration with the Fulbright researchers, we further contributed to Songani by providing meat and snacks for a Christmas Day celebration, and by submitting grant proposals to three funding organizations for funds to extend the income-generating activities provided by the community centre. These grant-financed activities are still ongoing, and will remain functional and fully financed until the end of 2004.

Despite this agreement, however, once I'd commenced the interviewing process it became obvious that some further remuneration to the individual families would be appreciated. The previous year's harvests had not been good, and many families were suffering food shortages. Furthermore, they were taking time out of their farming schedules to be interviewed, and this had to be recognized. I sought advice from my research assistant and some staff members at CSR and came to the conclusion that I would provide snacks (soft drinks and bread rolls) and token gifts of food and/or clothes to each of the families visited. Each family received a parcel with some salt, oil or maize (depending on which was available that week) and some items of clothing (many of these were brought over to Malawi for me by visitors from the UK). These were received with gratitude and eased my conscience for taking time away from agricultural activities. No doubt, though, this further contributed to the desire to be interviewed, felt by many in the communities.

In Galamadzi there was no structure akin to the Songani Community Care Organization through which to operate and, therefore, I had my research assistant Philip Tambala identify case-study families for me. While many of these families were distant kin to Philip, and it could be argued, therefore, that he selected relatives for me to interview in order for his extended family to receive the rewards associated with being interviewed, I do not feel that this prejudiced the results in any significant way. Firstly, kinship ties within a village are so profuse that there are very few people who aren't considered kin – the very fact that people live together in a village assumes some kinship basis (see Chapter 3). Since social ties are virtually synonymous with kinship ties, it would have been difficult for him to have located families who aren't kin. Secondly, his selection of case-study families was based on the same criteria as the Songani selection, so case studies still fell into the same general category regardless of kinship ties.

Since there was no facility through which I could make a donation to benefit the community as a whole, I continued the practice of providing individual families with bags similar to those I'd given out in Songani. After hearing quite often that school supplies were always difficult to acquire, I made a further donation to the school of exercise books, pencils and children's reading books for the library. My contact with residents in Galamadzi was, however, primarily at a family level and, therefore, it was only those families who were interviewed by me who 'benefited' from my presence through gifts. It was in Galamadzi that I also encountered many people who would wait at my car while I was in the village conducting interviews or house visits (the car had to be left on the outskirts of the village, since there were no roads to people's houses) and, upon my return, would ask if they could be interviewed by me. Few of these people knew anything about my research, and were only there because they had heard that there was a *mzungu* asking questions and giving gifts to those who answered. Philip Tambala assured me that they would answer the questions even were I not to reward them for doing so, simply to be a part of the research process, and often urged me to interview them just for the sake of doing so. Due to time constraints, I seldom did this, though I would often discuss the purpose of my research with these people. It was in these instances that the full scope of the HIV

epidemic, and associated impact of orphan care became anecdotally evident. Few of the villagers who would talk with me had not lost a family member who was also a parent, within the past year. Standing at my car, parked in the hollow between two hills, I would be talking to between 2 and 10 people at any one time. Looking upwards I could see 12 households in the villages to either side of the road, in all of which at least one orphan was living, and everyone I was talking to was either directly looking after orphans or had a family member doing so.

Experience of the research process

Conducting research in a developing country poses problems for the researcher that are not usually experienced by those conducting research in a Western university setting. An erratic electricity supply at home meant that typing of fieldnotes at the end of the day was not always possible. The generally poor road conditions meant that travelling to and from research sites was actually an accomplishment in and of itself regardless of whether or not I was actually able to interview someone at the end of the journey. The fact that neither I, nor any of the families I was working with, had telephones meant that interview arrangements had to be made in person, and changes in availability – either mine or theirs – could not easily be communicated. While I was in Zomba, the political situation in the country was also rather tense. At one point our town was surrounded by the army, and access in or out required having one's car searched. The general shortage of food and the President's campaign for a third term were ever-present issues of political concern.

Data analysis

While in the field, a very broad preliminary categorization of interview responses was created. Various people's responses to questions were compared and, if necessary, further confirmation of trends was sought through participant observation. This process continued throughout the fieldwork period, and was further assisted by comments from my supervisor, Dr Margaret Leppard, and other researchers in Zomba. Furthermore, preliminary coding took place after twelve months of research. A friend, Magdalena Kaloianova, assisted me in using Microsoft Word to group

interview responses to individual questions. This helped to provide me with an indication of the extent of agreement between certain responses, as well as the variation.

Upon return to Queen Margaret, this preliminary coding was expanded upon, and analysis of data was accomplished using QSR Nudist 4 PPC for the Macintosh. Due to system incompatibility (there is currently no version of Nudist available for Mac OS X) data analysis was relatively slow going. Interviews were saved as Word documents but, initially, I did not have access to a version of Word that would run on OS 9, where Nudist was functional. Once this was rectified, progress with the analysis improved considerably.

Interviews were then saved as text files and imported into Nudist in stages. To begin with, the original set of interview questions was coded for the following broad categories: kinship, pregnancy, HIV/AIDS and death. These categories were decided upon prior to leaving for the field, based on literature reviews for the selected thesis topic, and questions had been structured around these themes (see Appendix 2).

Once fieldwork started, however, it became clear that 'pregnancy' would not be a central theme, since it had been included originally because I had intended to focus strictly on maternal mortality and AIDS-related deaths. Without this focus on cause of death, it emerged that pregnancy-related information was irrelevant to the main thesis. I was, however, getting some information that I found very interesting, so kept the pregnancy-related questions in the first draft of the interview. When coding, however, a broader category of 'sexuality' was adopted, which included information about HIV/AIDS, pregnancy, and initiation ceremonies. This category of data, however, is not included in this thesis (the HIV/AIDS information is included in the 'illness' category).

After preliminary coding in the field, and more extensive coding later, four main categories of data were finalized. These were: kinship, death, illness, and sexuality. The breakdown of each of these categories is illustrated below:

FIGURE 3: KINSHIP AND ASSOCIATED SUB-CATEGORIES

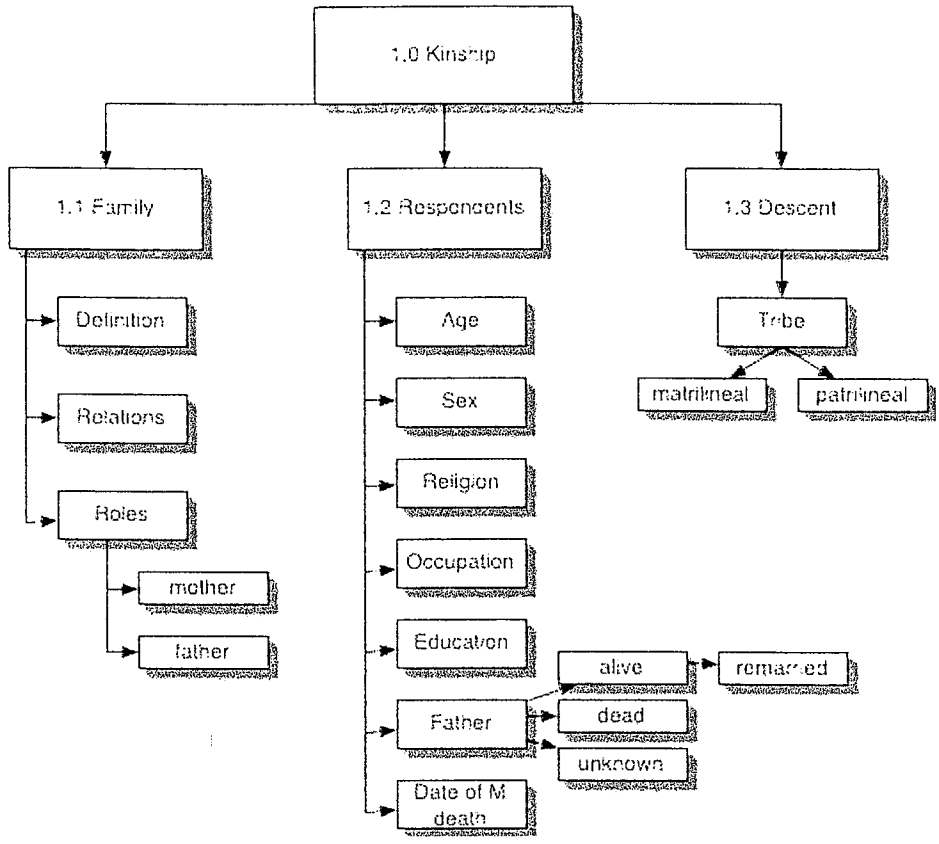


FIGURE 4: DEATH AND ASSOCIATED SUB-CATEGORIES

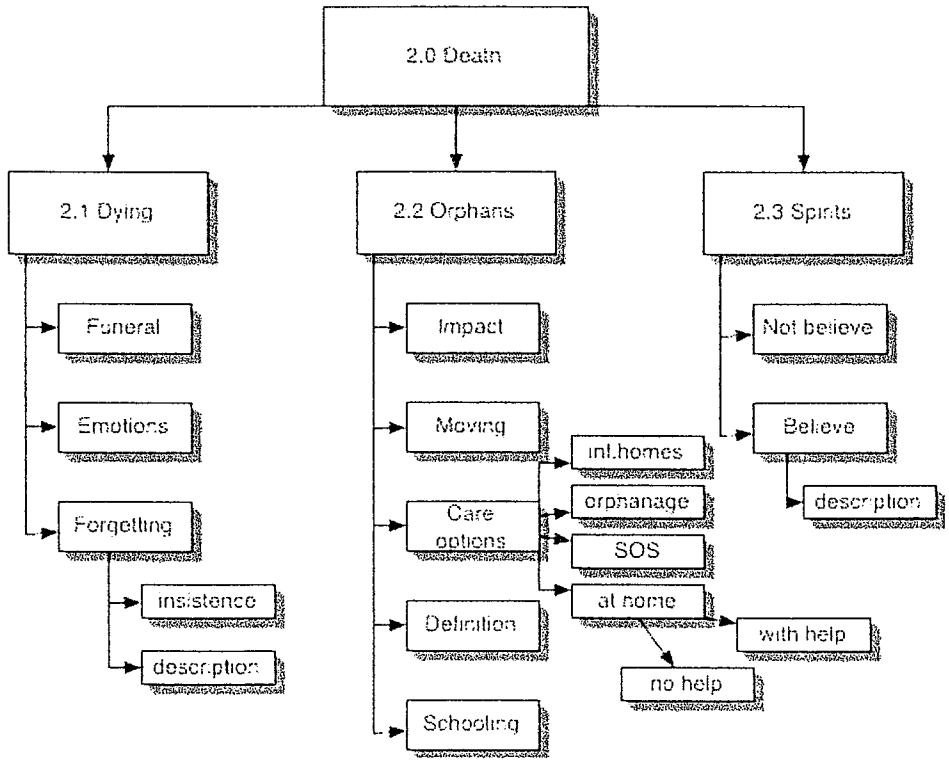


FIGURE 5: ILLNESS AND ASSOCIATED SUB-CATEGORIES

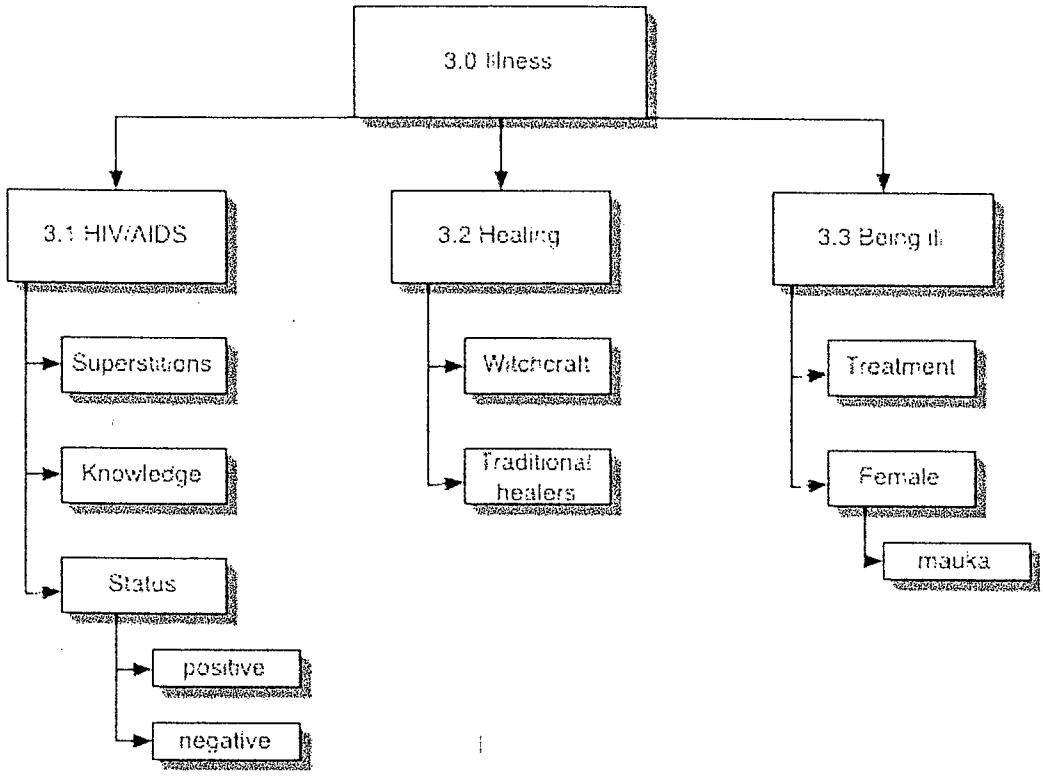
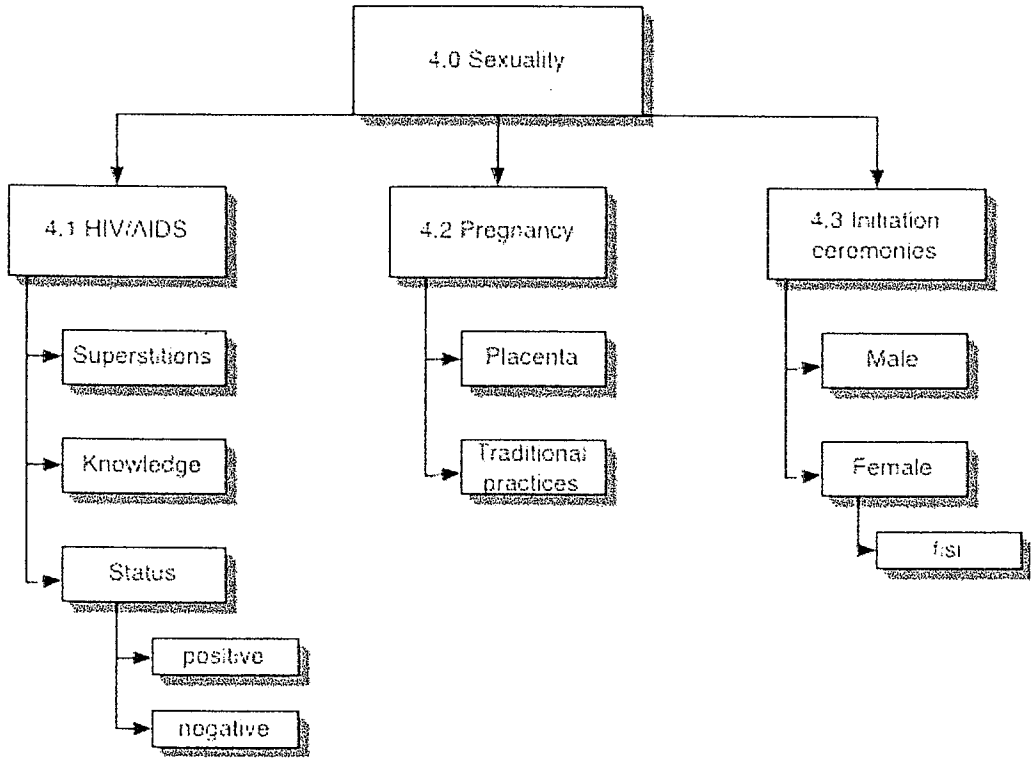


FIGURE 6: SEXUALITY AND ASSOCIATED SUB-CATEGORIES



Not all of the sub-categories presented above are included in the following discussion. Some of the data gathered was irrelevant to the central aim of the thesis, namely to describe the impact of a mother's death on her family and community. The sub-categories of 'pregnancy', 'initiation ceremonies', 'healing' and 'being ill' were omitted since they are not influenced by whether or not a mother is still alive.

Fieldnotes, written on a daily basis, were also integral to the following analysis. These, however, were less structured than the interviews and, therefore, not as easily coded. Anecdotes and accounts of conversations that were relevant to any of the sub-categories listed above were included where appropriate but, primarily, I accessed the data in fieldnotes by copying the various sections into the outline of the thesis, and incorporating them as I wrote up the thesis. Some notes were placed in multiple sections, just as many interview responses were placed in multiple sub-categories in Nudist. In the course of analysis it became evident that certain multiply-coded data sets clearly belonged to a particular category, but it remained true that many were of relevance to multiple sets, where they furthered my understanding of the relevant feature.

Quotes and information from literature were incorporated in a similar fashion: as I came across quotes that I thought would be of use, I would type them into the outline of the thesis. I also maintained a separate word document with citations from documents, or brief summaries of particular documents. This readily accessible information was included in the final write-up as and where it was relevant.

My bibliography was maintained using an on-line database, ecoport.org, with keywords used to associate particular references with the appropriate theme. This meant that at any time I could access a bibliography associated with the chapter I was working on and confirm that I had cited the relevant information and references.

Using Nudist as a data management tool is a slow and laborious procedure. Therefore, once I had an index tree of themes that I found sufficient to use as an outline for my thesis and which served to organize my data into separate codes, I did

not re-visit the fundamental structure of the tree. In hindsight, were I to re-organize the tree to better reflect the priorities of the thesis, I would create a separate category for 'orphans'. The rationale for the original placement of this category under the broader one of 'death' was that death is a prerequisite for the existence of orphans. It is clear now, however, that their importance to the social structure, and to this thesis, merits their own discrete category.

A total of 78 interviews were conducted with 66 individuals. Of these interviews, 46 were with case studies. Of case-study interviews, 29 followed the original schedule of questions (though when children were interviewed questions dealing with pregnancy and sexuality were omitted). A further 25 follow-up interviews included many of the individuals who'd answered the original set of questions. Of the respondents to original and follow-up interviews, 29 were caregivers and 17 were orphans.

Six interviews that dealt primarily with HIV/AIDS were conducted with HIV-positive members of the Limbikani AIDS Support Group (LASG). A further 14 interviews were done with 'general informants', people such as nannies at Open Arms Infant Home (OA), a pastor, several teachers, and volunteers associated with the Songani Orphan Care Community Group (SOCCG). A breakdown of interview respondents by name and location is provided in Appendix 4, which also includes a brief description of the extent of my contact with each individual.

Presentation of results

The thesis is structured around the five main themes to emerge from fieldwork, namely kinship, HIV/AIDS, death, orphan care, and the role of external agencies in assisting communities to care for orphans. Each theme is explored in a separate chapter, and a review of the associated literature is integrated with a discussion of the issues and fieldwork results. The topics covered are related, and all feed into an understanding of the impact a mother's death has on her family and community. At the same time, however, the literature surrounding each issue is very distinct. I felt that presentation of the literature review as a separate chapter would be unwieldy,

and would create an artificial separation between the literature and the results of my fieldwork. Rather, I integrate the two in order to demonstrate that, while the case studies and conclusions discussed in this thesis are particular to the individuals involved and to the fieldwork site, they resonate with a wider body of literature. This also highlights the fact that the scale of the crisis presented in this thesis is such that the growing number of orphans represents a regional crisis, rather than being limited to the communities examined in this thesis, or even to Malawi.

Conclusion: Reflexivity in fieldwork

This thesis is written in the first person in order to clarify that the conclusions drawn are an interpretation of native statements on the part of the researcher. Direct quotes have been used in many instances to give a voice to those who participated in this research. Wherever possible, effort has been made to indicate how externalities may have influenced fieldwork results. It is worthwhile, however, to flag two main influences at this stage. As mentioned previously, the ongoing famine during the period of research may have contributed to a focus on the material drawbacks of a mother's death. There is a possibility that when food is not so scarce responses may emphasise the emotional aspects of such loss to a greater degree. A second element that potentially shaped interview responses relates to an issue outlined previously in this chapter, namely the differing understanding of my research goals on the part of the informants. This is a common feature of social research and one that I attempted to address by being explicit about my goals and repeating them on many occasions. Participants' previous experiences with researchers and preconceived ideas, however, may sometimes have been stronger than my reiterations and, thus, may have influenced some of the responses provided during fieldwork.

The conclusions drawn throughout this thesis are based on observed realities in the field but are obviously mediated through my own interpretation. As Hammersley and Atkinson point out:

> ...research is an active process, in which accounts of the world are produced through selective observation and theoretical interpretation

> of what is seen, through asking particular questions and interpreting what is said in reply, through writing fieldnotes and transcribing audio- and video-recordings, as well as through writing research reports.... However, to say that our findings, and even our data, are constructed does not automatically imply that they do not or cannot represent social phenomena. (1996: 16).

The following chapters present the results of my fieldwork and data analysis. Separate chapters on kinship, HIV/AIDS, death, types of orphan care, and orphan care and development integrate my findings with the relevant literature. The results of my research are further discussed in the concluding chapter, which draws together the themes from the preceding presentations of data to highlight the fact that a mother's death has a devastating impact on her family, and the cumulative impact of such deaths is disastrous for Malawi.

CHAPTER 3: KINSHIP IN RESEARCH AREAS

In order to assess the impact a mother's death has on her family and community, it is necessary to understand local conceptions of 'family'. This chapter uses fieldwork data to critically examine definitions of 'mother', 'father', 'family', 'community' and 'orphan' in order to inform the reader of the manner in which they are used in the research area. The importance of kinship relations is also emphasized in order to highlight the profound impact that the loss of a kin member has on the social structure. An introduction of the strong sibling bonds that are established in childhood and which survive through to adulthood, also serves to preface a later discussion about the care of orphaned children and the decision as to who becomes the primary caregiver subsequent to a mother's death. Throughout, my research findings are contextualized using relevant literature.

Kinship ties are generally extremely important to societies within East and Southern Africa, and this holds true for those in the areas in which my fieldwork was conducted in Malawi. Kin constitute the primary source of support, both emotional and practical. People tend to live in close proximity to their kin, sharing labour for farming activities and childcare within the extended family. They rely on each other for financial loans. To a large extent, a person's community is made up of kin, thus an evaluation of the affect of a mother's death on her community is primarily an attempt to understand the impact of her death on her extended family.

While it is true that the primary impact of a mother's death is on her kin, the effect is not limited to this group. It is felt also on a much wider scale. In Malawi, the number of maternal deaths and concomitant number of orphans is escalating, and this has a detrimental impact on the country as a whole. It is a vital issue of national importance.

The discussion below provides the basis for understanding why a breakdown of kinship ties as a result of death has such a profound impact on Malawian society in general. The chapter begins by describing the kinship of the Yao and Chewa (the ethnic groups to which the majority of case-studies belonged) through a review of relevant literature. This description of local kinship is grounded within the wider anthropological literature on kinship, and contextualized using data gathered by the researcher during fieldwork. An analysis of gender relations is also provided within the context of kinship and social structure; the implications of the gender relations described in this chapter are further elaborated upon in the following chapter on HIV/AIDS. Finally, the chapter deconstructs the concepts of 'community', 'mother' and 'father' and 'orphan' using definitions of these concepts provided by interviewees. This serves to personalize the understanding of kinship and highlight the strong ties that exist between kin. The severing of these ties upon the death of a mother is particularly profound given the importance attached to kinship in the fieldwork area.

Kinship patterns and gender relations among the Yao and Chewa peoples

The area in which fieldwork was conducted is populated predominantly, though not exclusively, by members of the Yao and Chewa ethnic groups. It is important to note that even those individuals who did not identify themselves as either Yao or Chewa followed the customs of whichever group was dominant in their area. Residence plays a crucial role in dictating the traditions followed by any individual. An example of this is that all respondents claimed that they were 'matrilocal' and 'matrilineal', despite some of the women interviewed having come from neighbouring Mozambique, Zimbabwe or Zambia and, hence, were obviously not living in their mother's village. Since there is no direct translation of the words 'matrilocal' or 'matrilineal' in Chichewa, interviewees were asked: *mumakhala chikamwini kapena kwanu*?[5]. This phrase more accurately reflects residency patterns,

[5] The questions were asked in Chichewa, the language used for most interviews, even with those of Yao background, since the former is more widely spoken. Some interview questions were translated into Chiyao during the interview if a need for further clarification arose.

and a more correct translation asks 'are you living in your spouse's village or your own?' While the Chichewa term for matriliny is linked to residency patterns, this concept describes a number of features of social organization and is not limited to patterns of residence. Kings Phiri (cited in Miller, 1996[6]), outlines it as follows: '...matriliny among the Chewa is a complex of several variables, including the nature of marriage, residence during marriage, the exercise of domestic authority and the control or custody of children'. He maintains that women are respected as 'reproducers of the lineage' (ibid.) and that the concept of 'mother right' entitles them to remain in the village of their kin and to have control over children from their own marriage.

Most marriages within Central and Southern Malawi are matrilocal, defined by the concept of *chikamwini*, where the husband moves to the wife's village and builds a family house there. A man's access to land, therefore, is dependent on his wife's family. The combination of matriliny and matrilocality is often mistakenly assumed to provide higher social status to women but, unfortunately, this is not the case. While the lineage is traced through the female line this does not give women any real power (Isabel Phiri, 1993; Miller, 1996). A woman's brothers and maternal uncles are regarded as the heads of family, and it is from these ranks that a village headman will usually be chosen. Three villages surrounding those in which I was conducting interviews, however, had female heads of village. When I asked about this, I was told by Mr Mpoya that it was because '*the men in the family died. Or maybe moved away. There are none to be leaders*'. It is possible that with advances being made in gender awareness within the legal framework, together with the high death toll associated with HIV/AIDS, more women will gain the role of village 'headman'. Gender relations may change as a result of this, but it is still too early to assess the possible impact of this phenomenon within the specific context of HIV. It would be unrealistic, however, to assume that placing a few women in positions of authority would have any significant impact on their social status in the short term because: women are the more numerous victims of the HIV epidemic; they also bear the main

[6] http://www.brocku.ca/epi/casid/miller.htm

burden of caring for others affected by AIDS-related illnesses; and women provide the bulk of agricultural labour for the household.

Miller further outlines the kinship pattern of the Chewa as follows:

> The Chewa matrilineal system is based on the dual concept of *mbumba* and *nkhoswe*, which form the *banja* or family group. Along with the practice of *chikamwini*, these have been identified as the basis of the Chewa social, political and economic system (K. Phiri; Khaila; Mandala). The *nkhoswe* is the custodian and guardian of the *mbumba* who are the female members and their offspring in a family grouping. The *nkhoswe* is usually the senior brother or maternal uncle and his responsibility extends to his sisters' children. These *nkhoswe* are expected to ensure that the people for whom they are responsible have access to the land they need and that the women get married to providers who will support them properly. It is his duty to instruct the sisters' children who inherit his land, livestock, tools, food, etc. (Khaila, 34). His own children are not his responsibility. They are part of the *mbumba* of his wife's family line and the responsibility of the wife's *nkhoswe* (senior brother or maternal uncle). The *mbumba* owe their *nkhoswe* respect, contribute to his status by being numerous and are '... part and parcel of his economic unit' (Khaila, 34). (ibid.)

There is evidence to suggest that in pre-colonial times women had greater access to positions of influence and status, though both Isabel Phiri and Kings Phiri highlight that this was already being eroded by slavery and the patrilineal impositions of invading Angonis by the time the British colonists entered Nyasaland (as cited in Miller, 1996). It was colonialism, however, that forced the greatest change in kinship structures and gender relations. Miller identifies three significant aspects of colonization that influenced women's status in Malawian society:

> First, the introduction of the cash economy contributed to the differentiation of rural labour into commercial versus domestic production. Secondly, the ideological underpinnings of the European/British colonial system was male oriented. Imperial laws, land holding practices, religion and cultural mores reinforced pre-existing patriarchy and continue to do so. The third major modification of traditional society introduced by colonialism comprised the new social relations of capitalism strengthening patriarchy.

In addition, one must look at the role of European missionaries in influencing gender relations in Malawi. Isabel Phiri maintains that, 'colonialism allowed women some new opportunities not available under the pre-colonial system but reinforced a number of tendencies that put women at a great disadvantage ... the missionaries refused to recognize that, in an African context, it was often the women who played headship roles in religious matters.' (I. Phiri, 1993: 50). Christian principles promoted patriarchal values, which further undermined the status of women.

With regard to the kinship structures of the Yao, these are largely similar to those of the Chewa. Robin Fox provided the following description of the Yao in Malawi:

> They are agriculturalists and cattle herders living in relatively permanent settlements. They are divided into matrilineal clans, but these seem to have few functions. Each clan is divided into exogamous matrilineages, knows as 'breasts' (*mawele*). The effective group is a small matrilineage – the descendents of a common great-grandmother. This usually consists of a group of sisters and their children under the leadership of their eldest brother, forming a small village. But how does the brother come to be there? ... One of the brothers – the eldest – is exempted from the rule of matrilocal residence. He becomes the headman of the village with the right to rule over his sisters and their children. (1967: 105)

While cattle ownership was non-existent in the area in which my fieldwork was carried out, the Yao are agriculturalists who live with their maternal kin. With respect to descriptions of both the Yao and the Chewa (and kinship systems in general), however, it must be noted that these accounts are generally idealized. The reality of kinship within a specific context often varies from the ideal, particularly when subject to stresses akin to those experienced by communities in Malawi at the time the fieldwork was undertaken. These include increased death rates and famine. In his introduction to *Kinship and Marriage*, Robin Fox cautions that:

> I will frequently talk of 'models' of systems. By this I mean much what an economist means when he speaks of a 'model' of 'perfect competition', for example, or a physicist when he describes the behaviour of an 'ideal' gas.... Many of the 'systems' of kinship and marriage that I will describe will be models in the sense of limiting

> cases. Almost all 'real' systems will have some idiosyncratic variations. (1967: 25)

The discussion following illustrates some of the strategies employed by families in the area that I studied. It is not exhaustive and is not a study of kinship *per se* in that I did not analyze kinship terminology extensively. I have drawn some kinship diagrams to indicate the extent of incorporation of orphans into families, but not to understand the history of lineages. Neither did I attempt to understand the relationship between biological and social ties outside of a particular context – that of the adoption of orphans. It is, therefore, somewhat limited with regard to kinship theory, but is nevertheless important.

Kinship among case studies

In terms of ethnicity, case studies interviewed for the purpose of this thesis confirm the geographic distribution of ethnic groups in Malawi. In each location, self-identification of interview respondents by ethnic group resulted in roughly 44% of families declaring themselves members of the Yao, 31% as Chewa and 6% Manyanja or Magolo. A further 19% traced their background to the neighbouring countries of Mozambique, Zambia or Zimbabwe (though often also characterizing themselves as either Yao or Chewa). All families identified themselves as matrilineal, and the majority of carers of orphans in both locales were female – sisters or mothers of the deceased.

Families in both locations rely primarily on agriculture-related activities as their main source of income and the average size of land holding is 0.5 hectares (Overpeck, personal communication). Below is a range of answers received in interviews regarding the families' main economic strategy – these activities are representative of the majority of those utilized by many of the rural poor in Malawi:

> Question: How do you earn a living?
> *Gladys: I sell farm yields.*
> *Linly: Am doing a business of buying and selling fish.*

Daina: By selling firewood

Ignazio: I get it through farming.

Dora: In those days I used to sell firewood but at the moment am just staying.

Mai Austin: I am doing business – selling sweet potatoes, tomatoes and lemons.

Damiano: By field work.

Catherine: We sell doughnuts.

Philip: We find money through farming and selling sugar canes. We also make some woodcrafts and sell them.

Lonnie: I depend on agriculture. Sometimes I sell groundnuts and sell myself to do field contract.

Malita: I depend on agriculture.

Case-study household sizes ranged from five to eleven, i.e. the number of people an interviewee stated as living in the same house. This does not, however, paint the full picture. In many instances a household would have a certain number of members who slept there and/or who worked in the nearby fields, but the female head of household would also be providing meals, financial support and/or clothes for a large number of orphans. Below are synopses of the case studies of three individuals who are caring for orphans: these stories illustrate the wide variety of mechanisms that are employed to care for orphans.

Stella is a middle-aged woman who is married. Her husband is alive, though he often works in Mozambique (where his family originates). When he is in Malawi he gets occasional work as a domestic employee or gardener. She works as a maid, and has managed to work more often than not. She has four children of her own, all of whom in turn have had children of their own. Of her children (3 female, 1 male) one female and the male are still alive. The two daughters who died left seven children between them. Stella is nominally caring for all seven, though they are now living with her remaining (middle) daughter. Her daughters died approximately 3 and 4 years ago (based on her estimate of how long she has been looking after the children). The youngest

daughter was living with her at the time of her death; she wasn't married, and had four children by three different men. Stella disapproves of this, but '*her [daughter's] children are my children.*' She talks of these grandchildren in particular with great warmth, affection and pride, and there is definitely the understanding that they are welcome, no matter their illegitimacy.

Stella's surviving daughter used to work at the St Luke's hospital but was fired more than a year ago and has not been able to find work since, and has a son of her own. Her husband left her when she agreed to take in her sister's children. He occasionally sends her money or food, but this help has been getting more infrequent lately. Because he has moved to Liwonde, nothing is known of his situation and Stella does not know if he has remarried, though suspects he may soon. Stella's son of whom she seldom speaks, works as a woodcarver and farmer. Her references to her 'family' almost inevitably mean her daughter and grandchildren rather than her son and husband.

Stella is a member of the Roman Catholic Church, attends church meetings twice a week as well as the regular Sunday service and is a member of the choir. This membership has frequently created conflict between her and her employers, since she is often called upon to sing at funerals. '*It is my duty to sing. Even if another person could sing for me I would still go. It is my way of showing respect. Also, I suffered myself when my daughters died. Singing [gives] people comfort. Lots of people going to a funeral mean that family who is still alive will have help. They will know God loves them and sends people to help.*' Her church has often had sermons about the problems of HIV/AIDS in the community, and Stella tells people that her daughters are dead because of '*that edzi disease*'.

Philip, woodcarver and farmer, worked also as my research assistant for a period of my fieldwork. At 22 years old he is married, and his wife has recently given birth to their first child. He attended secondary school, though did not complete the course due to the birth of his daughter. He tells me that

he did not want to have children this young but intended '*to wait until I am older, as the radio says*'. When I asked him why he did not use contraceptives he shrugged and did not reply, even when pressed. Towards the end of my time in Malawi, his wife became pregnant again. Their daughter was seven months old at the time, often sick with malaria (as was his wife). Philip was very concerned about the health of both his wife and daughter. I gave his wife multi-vitamins to take, and bought them a chicken so that she could eat eggs (though there is the possibility that these may be sold to raise cash). Doreen, my other research assistant, lectured him severely about the fact that it was wrong for him and his wife to have sex so soon after she had given birth. She told him that the contraceptive *Depo Provera* is free, from health clinics, and that his wife should go to a clinic after she'd given birth this next time to get an injection. There is a strong possibility that his wife will not survive this latest pregnancy, due to her being so weak and sickly, as well as malnourished.

Philip's wife is from a neighbouring village but, because he is the only male left in the family, they live in his mother's village. He had four sisters, three of whom have died in the past two years. Two of them left children who are living with his younger sister and mother in a house that he built uphill from his own. It is obvious from the houses and his conversation that he has been a relatively successful carver. Well respected in the village, he uses his position as my research assistant to enhance his prestige. Unfortunately, there are now many more carvers than even a year ago, and between the resultant increased competition and successive bad harvests, his economic situation is deteriorating rapidly, though he is still obviously better off than many others in his village. Support for his family and his sisters' orphaned children is in the form of the houses he provided, his wife's work in his family's fields (along with his mother and sister), and he provides them with clothes, many of which I gave to him while he was working for me, and which he has subsequently re-distributed among his family.

Mai Eunice is the grandmother of David, an orphan who lived at the Open Arms (OA) Infant Home. David, the son of one of Mai Eunice's daughters, was at OA for two years, following his mother's death two days after giving him birth (apparently as a result of post-partum haemorrhage (PPH)). I met Mai Eunice when she came to take David home, since orphans are only allowed to stay at OA until they are two-years-old. She hadn't seen David in the two years that he'd been at OA, since she couldn't afford the money for transportation. David's father is no longer in contact with either her or David. When his wife died, he left her village to look for work and it is thought he may have gone to South Africa. Mai Eunice also cares for David's two older siblings, who were too old for Open Arms. She lives with her sister, a widow with no children of her own, and they grow sugarcane. Mai Eunice has had nine children, seven of whom have died. The two remaining daughters live in her village, help her with the farm work and sell, at the local market, the tomatoes that they grow. Both have children of their own, and also look after the children of their dead siblings – *'perhaps there are fifteen (children, including orphans)'*.

Mai Eunice's whole family contributed the money for her to collect David. On leaving, David was given another set of clothes, some *ufa* (maize flour) and a toy. She thanked the OA staff profusely, but it is obvious that such a small bag of *ufa* will in no way satisfy much of the family's need for food.

The case studies above illustrate how essential kinship ties are to the survival of most orphaned children. For most of the people I interviewed, it appears to be literally unthinkable to think that a family member might refuse to care for orphaned children. When I asked the question 'can a person refuse to look after orphans', the majority of people simply could not answer. Of those who did provide an answer, the following indicate the extent to which it was unthinkable to refuse, mainly because they understood that there were no other options for these children.

Catherine: That cannot be possible.

Edith: No, because if it was done, that means the children could have nobody to be looking after them.

Malita: It cannot happen just because when you refuse what can the children do?

Question: If it was you who refused to look after these orphans would anything happen to you as a person?

Malita: Nothing could have happened to me, as I know that there was nobody to take care of the children.

This is not to say, however, that the responsibility of orphans is accepted without qualms or reservations. Since poverty in rural areas is such a threat to household survival, and is worsening, people acknowledge that caring and feeding for extra children jeopardizes the survival of other family members. Husbands, whose wives take in orphans of their kin, may leave as a result of this extra burden, thus further jeopardizing the well-being of all the children by removing support. Furthermore, if children do remain with their father following the death of their mother, problems tend to arise if and when he re-marries.

Below follow several scenarios experienced by case-study families subsequent to a woman's death, illustrating some of the issues surrounding the decision to care for orphans.

Mary was looking after four orphans, who had a further three siblings staying with their father. This decision was made by the father, who'd suggested having '*some of the children, and the rest being kept by me due to the fact I could not manage them all.*'

Catherine, in addition to having six children of her own, was responsible for four orphans who were living in her mother's house because the house of the sister who'd died had collapsed. Even though they were living in another family member's house, Catherine pointed out that '*in terms of food (and)*

clothing they depend on me. They do farming with their Granny, but they are eating at my house, because their Granny is very old.'

Fidelia pointed out that she wasn't receiving help from siblings in looking after a deceased sister's orphans because '*my brothers are not in good condition (sickly)*'. When asked why her sister was not helping, she replied '*lack of funds*'.

Feria took her sister's four children away from their father, who had been looking after them for a year, when she saw evidence of them being abused by his new wife.
Question: So how long did the children stay with their father?
Feria: A year.
Question: Did you discuss their removal with their father or did you just take them?
Feria: I discussed with the father and he was angered that his wife was ill-treating the children.
Question: Do all four children stay with you?
Feria: I am looking after all of them.

Sometimes, however, there are no relatives capable of caring for orphans, in which case the phenomenon of 'child-headed families' is created. Following the death of his mother eighteen months previously, Ignazio, an orphan aged 24 years, had been looking after some of his siblings for the past year. Initially he and his siblings were cared for by an aunt but, because she could not afford to look after so many dependents, he made the decision to create his own household: '*I decided to be looking after my brothers as they were many children relying on one person, who was also very poor.*'

As the number of orphans increases while the number of carers decreases, the emergence of child-headed households is an issue of mounting concern in sub-Saharan Africa. It is closely linked to the increasing rate of HIV infections and

deaths. UNICEF and Save the Children Fund, among other organizations, have made the identification and assistance of child-headed households a key priority. There is still, however, little data on the prevalence of such households, or on the long-term impact that such living arrangements will have on the children themselves and the communities in which they live. This category of orphans is a particularly vulnerable group, even in Malawi. It appears, however, that Malawi has fewer such households than have neighbouring countries. Possibly, though, this seems to be the case because Malawi has not placed as much emphasis on identifying such households, and has not investigated the phenomenon as much as has been done, for example, in Tanzania, Zambia and South Africa. During my fieldwork, though, I did not encounter any families that fell into the strict definition of 'child-headed households'. While some of the families I met were headed by young adults (early twenties), none were headed by official orphans (i.e. aged eighteen and under). I have not found a source of statistics that compares the number of child-headed households between countries and assume this is because the phenomenon is fairly recent and easily masked within communities.

The lack of statistics, however, does not negate the severity of the problems faced by orphaned children. Rob McBride discusses research he carried out to analyze the educational needs of AIDS orphans in Zomba. He has the following to say about the numbers of orphans and vulnerable children:

> Estimates of numbers in such situations are often misleading – they are difficult to collect, tend to ride roughshod over the views of ordinary people and may not provide a satisfactory basis for perceptive action. 'Indeed, the numeric shroud may well obscure far more than it reveals' (Samoff, 1999: 77). This project has not dealt with numbers and I feel that for many (obviously not all) purposes we do not need them. We can say that there will soon be a significant minority of children and young adults in Malawi for whom life will carry a set of negative meanings. Aside from the personal distress and unhappiness they have experienced there is a considerable risk that this group will spawn a disillusioned underclass whose only realistic prospect of personal development is through crime. (2001: 1)

There are instances of families who fail to care properly for orphans, for instance, by favouring their own children over those of others. Often, this significantly affects the health and future earning capacity of these orphans. Such cases are fewer, however, than are those where orphans are simply absorbed into the family as a new child irrespective of parentage. There is a danger that cases of orphan neglect will increase along with the increasing number of maternal deaths and orphaned children. It is possible that they are more common than is realized since this is a difficult issue to study and one that would require dedicated research over a long period in order to fully gain the trust of the families under investigation. Consider the example below:

> My neighbours in the government housing where I initially lived in Zomba were both given their houses through the military. The one family, who were there when I moved in, consisted of Mai Monica, whose husband had died while in military service, her daughter Monica, her older sister, Mai Thomas, and her sister's son Thomas, an orphaned niece Regina, and Febe and Dave. Febe and Dave are orphans from Mai Monica's home village, related through a 'sister' (actually an aunt – the terms are often used interchangeably) and sent to live with Mai Monica because she is relatively well off. She receives not only a widow's pension from the military but, Monica's school fees are paid for, she owns a mini-bus which Thomas and an employee operate, and she works at Chancellor College. Regina now goes to school in Blantyre, where she lives with another aunt, but spends her school vacations in Zomba. She prefers life in Zomba because she has playmates in Monica and Thomas. Other relatives visit at different times, particularly Mai Thomas' oldest daughter who used to live here before getting a job in a shop in Blantyre.
>
> Febe looks after the household during the day, along with Mai Thomas, and Dave works in their garden. They are treated similarly to other members of the household, and it was only after a couple of months that I realized that Febe and Dave weren't Mai Thomas' children. They are well clothed and eat their meals with the family, and Febe is as likely as either Monica or Regina

to tell me that I must eat with them on any particular night. They are worried about my diet because I don't eat enough *nsima!*

Another neighbouring family arrived several months after I moved in. The father, who is seldom at home, is in military service. His family comprises his wife, Mai Edwin, and their three sons. Mai Edwin gave birth to a fourth son in December 2001. At that time, too, her sister and her sister's son came to live with them. There is also one orphan that they are looking after, Tenya, who is treated little better than a slave. She tells me that she is thirteen years old, though I and other friends can hardly believe it. She appears to be no older than about eight. She is literally dressed in rags, and works very hard, carrying empty soda bottles to the kiosk, exchanging them for full ones, and then carrying these back to the house to sell. She cleans the house and does most of the cooking, as well as weeding the back garden. The boys all have brand new clothes, go to a private school and have many Western-style toys, bought for them in South Africa by their father when he travels.

One issue with the disparity between the way in which orphans and non-orphans are treated within a family is that this difference is more apparent in urban settings than in rural. Families like the two outlined above are better off economically than their counterparts caring for orphans in villages. When they treat orphans differently from their own children the disparity is more noticeable. In villages where everyone is working very hard, is wearing threadbare clothing and is going without food, it is harder to assess how ill treated an orphan is compared with others in the same household.

Some literature (e.g. Preble, 1990) cites evidence that orphans are poorly treated within households. Personally, I did not see any examples of this during the course of my fieldwork in villages. It is usually impossible to determine which child is an orphan and which is not through observation only. Phiri and Webb (2002) point out that UNICEF's research highlights the fact that, because so many orphans are absorbed into their extended families, the wellbeing of the non-orphaned children

whose parents are caring for orphans is jeopardized. Households who foster orphans become poorer with the extra demand on resources and this poverty is generally felt equally between all members of the household. Within my fieldwork situation, it was usually only through asking if a specific child was an orphan that its status could be verified, given that they were all apparently treated equally, were dressed similarly, and had comparable levels of responsibilities within the household. Caregivers themselves stressed the importance of assimilating a child into the family completely, as well as the necessity of treating all children alike. A key concept in this process is the idea that an orphan must actively 'forget' his/her mother; failure to do so results in significant health problems, possibly even death. This is achieved through incorporation into a new family unit. This concept of active forgetting is discussed in more detail in Chapter 5.

Malawian kinship within an anthropological framework

A crucial element highlighted by all the previous case studies is the inclusive nature of Malawian kinship. Assistance and caring, as expressions of kinship ties, are extended well beyond the immediate family. However, despite these wide kinship ties, evidenced during daily activities as well as subsequent to stressful life events, definitions of 'family' remain rather strict and heavily influenced by Christian/Western ideology. The majority of interviewees defined 'family' (*banja*) as *banja munthu wamkazi ndi mwamuna amakhala malo amodzi kumeneko ndi kugonora malo amodsi* (a family is where a woman and a man live together in the house). When explicitly asked if it would still be a family if either the husband or wife were absent or dead, the overwhelming answer was *ndiye kutu banja palibe* – *'that's not a family'*. In conversation, these remaining family members are simply widows or widowers looking after children. Examples of some of the narrow definitions of 'family' received in interviews are provided below:

> *Gladys: A family is an agreement of living together between a woman and a man*
>
> *Mai Austin: It is two people: a husband and a wife.*
>
> *Ignazio: A family is a woman and a man who are married.*

Malita: It is two people, a man and a woman.

Dora: A family is a husband and a wife.

Catherine: A family is where a man and a woman live together in one house. If a man or a woman is not there, then that is not a family. If the husband is not there, the wife is now a lady.

Grace: A family is a mother and father who live together with their children.

Philip: A family is where a man, woman and children live together.

Lonnie: A family is a wife and husband who are living together faithfully, loving and caring each other.

Linly: A family is where there is a man and a woman living together.

This narrow definition of family is echoed in an article by Charles Chilimampunga (1999: 74), in which he discusses gender relations in Malawian radio broadcasting. One of the sample radio commercials supplied for analysis in the article is one on family planning, for which the script goes as follows:

Male 1: Child-spacing is your responsibility, father.
Male 2: Most of us fathers know our family responsibilities. We mean to take care of our wives and children, to ensure that their daily needs are met...
Male 1: Child-spacing is your responsibility, father.
Male 2: As the husband and head of household, you should teach your wife about the importance of child-spacing if you are to manage to take care of your children, to feed, clothe and educate them without difficulties...
Male 1: Child-spacing is your responsibility, father.

Chilimampunga analyses this as depriving women of the power to make decisions about family planning matters, 'she is portrayed as a passive wife and mother, waiting to be taught and cared for' (ibid.). Another item of interest raised by the commercial, and key to this discussion of kinship, is the idealization of the father's role within the family. Other commercials cited by Chilimampunga also demonstrate this romanticism of family, for instance through the portrayal of women as stay-at-home mothers only interested in cooking and cleaning. Given the high numbers of men who work as migrant labourers, women provide the majority of household income for daily use. They do this, predominantly, as domestic helpers and through

employment in the informal sector. This situation is largely ignored. Despite the critical aspect of women's work to the survival of the household, it is denied in formal discourse, as is the reality of Malawian families caring, either directly or indirectly, for many orphaned children. Instead, a very Western portrayal of families is encouraged over the radio, a medium that is listened to widely by Malawians and which has proven to be an effective tool for social change (ibid.).

These narrow descriptions of *banja*, however, do not reflect the realities of kinship as observed during fieldwork. They form only one element of such a designation. A further element of Malawian kinship is of relevance to this discussion. When questions concerning relatedness were translated into Chichewa by my research assistant, Fadi, the term 'relatives' was translated as '*kukhala amagazi modzi*'. This literally translates as 'those living together who share the same blood', and hints at an interesting aspect of kinship ties.

As outlined in the introduction, of the various anthropological theories of kinship, two have been of primary importance in the recent history of anthropology. The first is that of *descent groups*, subscribed to by such anthropologists as Fortes, Radcliffe-Brown, Murdock and Evans-Pritchard. This assumed that the family was a universal institution and that the father bridged the gap between the domestic and public/politico-jural worlds. The descent group was a discrete number of individuals connected by way of biological lineage. Ties were traced either through the mother or father, depending on whether the society was matrilineal or patrilineal, and lineages act as a corporate group, particularly with regard to outsiders, and impose structure on society. Unilineal descent groups are exogamous and, therefore, they have ties to other lineages through marriage but descent is prioritized over alliance. In many respects, this description matches that of the Chewa provided by Miller (1996), above.

Alliance theory, of which the main proponent was Levi-Strauss (1969), argues the opposite to descent, i.e. it prioritizes alliance over descent in terms of its importance in structuring society. He looked at the universal structures of culture, basing his

investigations on the assumption that binary oppositions were a universal feature of cultures, and that only the elements of these oppositions differ cross-culturally. Mauss' (1954) work, *The Gift*, also informed alliance theory in that the principle of reciprocity was seen as key because it defines categories of ego and alter, thereby creating social relations between individuals and groups. In his book *The Elementary Structures of Kinship* (1969), Levi-Strauss begins with the assumption that exchange is the basis of society, and that marriage – the exchange of women – is the most important exchange. Women are the supreme gift, and the distinction between wife-givers and wife-takers was the original social categorization. Reciprocity principles exist in the deep structures of the mind and give rise to the incest prohibition, which is a universal feature of culture. The formalization of this rule in society distinguishes men from animals and became a precondition for exchange. This theory was revolutionary because it was not negative. Instead it explained incest as a positive injunction to marry out and succeeded in explaining it as a cultural phenomenon, thus avoiding the problem of biological explanations of incest, which don't account for the variety of incest definitions. While of interest within the historical investigation of kinship in anthropology, alliance theory does not immediately impact on analysis of Malawian kinship.

That does not mean, however, that Malawian kinship falls completely into the category of descent theory. Other idioms of kinship exist that are not strictly related to the above categories. Building on Levi-Strauss' observations in his *The Way of the Masks* (1988), anthropologists such as Janet Carsten have highlighted other ways in which kinship and personhood are theorized and produced in societies. Thus, the metaphor of the house for the body/person, which is common in much of South East Asia, is built upon in *About the House: Levi-Strauss and Beyond* (Carsten and Hugh-Jones (eds), 1995) to demonstrate how the house can be theorized as the ritualized social group. Andrew Strathern's (1973) research in the New Guinea highlands demonstrates the importance of residence and locality; people belong to descent groups, but these descent groups are defined more by residence than biological descent. Kinship is thus given a *processual* nature: these ties are ones which can be created and reinforced through everyday actions such as living together and feeding

each other. This categorization of kin ties as elements for which biological ties are insufficient explanations, is echoed by aspects of kinship in Malawi. Similar to Strathern's conclusions from New Guinea, Malawian kinship has elements of descent theory, which are reinforced by processual activities.

Kinship in Malawi is generally well characterized by descent theory, but this theory is not sufficient to explain the realities of kinship within the present context. Since families in Malawi also place a degree of importance on residency patterns, as for example in the translated term for 'relatives' and in the definitions of 'family' provided below, there is obviously another layer to kin patterns which goes beyond biological ties of blood.

When asked to define a family, here are some further responses that illustrate the complexity of the concept:

> *Tereza: It is man and a woman in one body.*
> *Ignazio: A family is where a man and woman marry and live together in a house.*
> *Mai Chauwa: A family is where a man and a woman live together in one house. If a man or a woman is not there, then that is not a family. If the husband is not there, the wife is now a lady.*
> *Grace: A family is a mother and father who live together with their children.*
> *Philip: A family is where a man, woman and children live together.*

Historically, the importance of residence has also been demonstrated by the inclusion of slaves into lineages in many African cultures (Perbi, 2001).

This combination of idioms of kinship – blood and residency – suggests that a separation of descent and processual theories of kinship is artificial and does not reflect the reality of Malawian living. Observations during fieldwork back up this statement. Descent is important in that children belong to their mother's family (within the matrilineal societies studied for this research) and, even when being cared

for by members of their extended family, remain within this lineage. Individual families, however, incorporate children as their own through everyday activities that emphasise caring and assistance. Socially, therefore, these children become the real children of their caregivers and are no longer defined as cousins/nieces/nephews but as siblings or offspring.

A closer look at the answers received to the question of how 'family' is defined, reveals that the idioms of blood and residency are joined by another, that of assistance.

> *Lonnie: A family is where there is a man and a woman living together and helping each other with the household work. What makes a family to be called a family is when the husband is there, assisting you in different ways.*
>
> *Mai Koloko: What makes a family to be called a family is when the husband is there assisting you in different ways*
>
> *Patricia: A family is where there is a man and a woman living together and helping each other with the household work.*
>
> *Edith: It is two people (a man and a woman) living in union as parents and caring for children you're having. In my case I am keeping orphans.*
>
> *Damiano: A family is where there is a man and a woman living together and sharing knowledge.*
>
> *Ellen: A family is when you've a wife caring for you*
>
> *Mai Harrison: A family is a wife and husband who are living together faithfully, loving and caring for each other.*

Care and assistance are daily re-affirmations of the kinship bond and are also responsible for maintaining these relations. Furthermore, they form the basis of a network of support that ensures that families have access to social capital in times of need. These kinship ties are strengthened through a variety of mechanisms; a variety that is necessary, since kinship ties are vital to the survival of both individuals and communities and are protected using strategies that reinforce each other. In the

absence of social support programmes provided by the government, it is up to the family and the community to implement mechanisms whereby the survival of individuals is ensured. Community-level responses are discussed in later chapters. It is important to note here, however, that the means by which communities cope with the ramifications of a mother's death are extrapolated from those means by which kinship ties are buttressed.

Among the number of elements that constitute kinship within the Malawian context, biological ties, as demonstrated by descent patterns, are important particularly in terms of deciding where a child will live following its mother's death. Residence patterns and assistance further strengthen kinship ties. Helping relatives farm their fields and care for children is an important expression of kinship that actively reinforces these ties. These three elements of kinship are all important within the context of orphan care since they contribute to the scenario in which orphans are automatically incorporated into the extended family and remain nurtured, to the best of the family's ability, until they are capable of caring for themselves. There are several ways, therefore, in which members of a family demonstrate that they are related, as evidenced by the variety of responses given by interviewees. Some of these responses are provided below:

Dora: They help each other in farming looking after their children, and finding food to feed them.

Grace: They help each other if they have a funeral in the village and to show respect to each other and also they have to assist somebody who is ill.

Mai Sani: To show that they are related, they do things together and also help other people if they don't have food.

Margaret: They love one another and a husband shows his being responsible over a woman. And relatives help in raising children.

Linly: Man most of the time takes care of their wives and the wife too takes care of her husband by showing love to each other and exchanging jokes and living happily in the family.

Ignazio: They make sure that they're of the same by visiting and agreeing with each other.

Edith: They show love to one another since they both sleep naked.

Mathews: They live in peace and harmony and help each other in doing things.

Daina: We have to do everything together, for example farming, eating and solving family problems.

Marcus: Each one shows love and tender care of one another.

Patricia: They love each other and do work together like farming and piece work so that they have money for food.

It is important to make one final point regarding the definitions of 'family' provided to me during interviews. Since these definitions are so narrow, and obviously not in keeping with the practice of kinship in daily life, one could query the relevance of the interview context in influencing the types of answer given and the fact that these answers were being given to a white person whom they might assume to be expecting such answers. I am satisfied that using my observations concerning kinship to influence my interpretation of the above answers has produced sound results (Hammersley and Atkinson, 1996: 131). Another potential area of influence on definitions of families is simply that of time. Engberg stated that 'what is meant by "family" is not the immediate or nuclear family of husband, wife and children, but the wider group or extended family' (1968: 3). Thirty years later, Chilimampunga (1999) pointed out that increasing exposure to Western values has influenced people's definitions of family. This may partly explain some of the responses given to me.

The nature of communities

There is no comprehensive definition of 'community' within social anthropology, largely due to the cultural variations that exist worldwide. The *Encyclopedia of Social and Cultural Anthropology* dedicates several pages to the usage and evolution of the term. Many of the definitions share an emphasis on 'social coherence' (Rapport, 1996: 114) and 'essential commonality' (ibid.: 115). Communities may

consist of villages or tribes, either of which may be created due to kinship ties, as is the case in Malawi. They are not, however, necessarily observable groups. For instance, virtual communities to which people with similar beliefs can belong regardless of residence locale have been created on the Internet. This highlights an important attribute of community, namely the way in which membership is marked. Essentially, communities exist because people create social relations, which they imbue with meaning and then proceed to mark the boundaries between themselves and others. 'Anthropologists, in short, continue studying 'community'...because this is what their subjects inform them that they live in and cherish.' (ibid.: 116-117).

The research conducted for this thesis could have reported the impact of a mother's death on her immediate family and her village but this would not have portrayed the sense of unity that is present among members of an extended family. The term 'community' resonates with a sense of belonging and a willingness to provide assistance to members. Furthermore, use of the term 'village' would exclude the impact of a woman's death as felt by relatives living out of this locale. These often participate in providing assistance to her orphaned children. I continuously emphasize the extended nature of the family within the Malawian context. This term, though, has different meanings for my readers and my informants. It is difficult to create boundaries between the extended family and others living in a village, either through assimilation of smaller villages, marriage, or as a result of incorporation of refugees (Mozambique) and migrants (Zambia). Thus 'community' echoes more strongly the realities of patterns of relatedness and reciprocity that occur at a village level but in which members who are not physically present still participate.

Reciprocity and assistance are key elements of communities in Malawi, and are highly functional in nature. Ressler, Boothby and Steinbock (1988: 147) highlight the fact that children's 'first ring of security' is the family. Their 'second ring of security' (1988: 151) is the community, which they define as consisting of 'relatives, teachers, and other familiar adults' (ibid.). They point out further that 'several studies on community responses during natural disasters point out that, rather than becoming paralyzed, disoriented, or reverting to self-survival types of behaviour, members of

an affected community may often become more altruistic, going to considerable lengths to help family members, friends, and neighbours.' (ibid.). This is demonstrated in Malawi, where communities are faced with a combination of natural disasters (periodic floods and droughts) and social disasters (famine, HIV/AIDS, various endemic diseases) on a regular basis, and where individual survival is often contingent upon community-level assistance. The kinscription of kin for shared mothering (Glenn, 1994) of children is a crucial contribution to the survival of future generations of communities.

Motherhood

Insofar as the role of being a parent defines a person's place in much of African society, it is of crucial importance. Furthermore, in order to fully understand the impact a mother's death has on her kin, it is necessary to understand the role that she plays within her family, and how this is understood and valued by other family members. To date, though, the role and responsibility of being a parent is better represented in literature than in ethnographical studies. Thus in literature, authors such as Buchi Emecheta (1994 [1979]), and Chenjerai Hove (1991) have explained the role of a mother in African society. However, while the specific nature of parenting isn't well examined in the social science literature pertinent to the area, the problem of an inability to become a parent has been widely discussed, reflecting on the importance of parenthood, in particular motherhood, in many African societies. There is an extensive amount of literature aimed at treating female infertility in Africa. The condition is relatively common due to prolonged and untreated reproductive-tract infections (RTIs) and the prevalence of sexually transmitted diseases (STDs). Sue Njanji Matetakufa analyzed the impact of infertility on women in Zimbabwe, where approximately one in four women suffer from some degree of the condition. The inability to bear children has a serious impact on a woman's quality of life. As Matetakufa explains, 'fertility is highly prized in Zimbabwe. Women without children suffer social rejection and are made to feel personally inadequate.... The pressure exerted on infertile women can be so great that even in the face of such deadly infections as HIV and AIDS some will take the risk and attempt to fall pregnant by multiple partners' (1998: 11). She relates the extent to

which infertile women are subject to mental and physical abuse from their husbands and relatives, and how infertility can be cited by men as grounds for a divorce. The relationship between personhood and parenthood is marked in Zimbabwe and in much of Africa.

With respect to females in Malawi, adulthood and motherhood are inextricably linked. The term used to address adult women is *mai*, literally 'mother'. When asking interviewees to explain the concept of a 'mother' to me, on several occasions I was told '*a mother is any woman*'. Other definitions of a mother included the following:

> *Grace: A mother is the one who has responsibility for everything in the house*
> *Linly: The mother is the woman while the father is the one who has beard.*
> *Ignazio: The mother is the one caring children while a father is the one who buys food and do other jobs for the family.*
> *Patricia: The one who is responsible for caring for the child at home.*
> *Philip: A girl becomes a mother when she is matured and has a family, but can also be a mother if she lives/stays with people or children who take her as a mother.*
> *Margaret: It is someone who is having responsibilities over a child.*

These definitions highlight the fact that the daily task of caring for a child is seen as a key responsibility of being a mother, a definition which resonates with that held by many Westerners. It is important, however, not to assume too much similarity between these definitions. It is also crucial to examine the gender context within which many of these definitions are made. To begin with, while in popular discourse it is the woman who cares for children within the home and the man who leaves the home to engage in economic activities that provide the necessary material possessions, this is not an accurate reflection of reality. Women are responsible for the greater proportion of household work and, often, also bring in significant amounts of income. As such, mothers are essential to the wellbeing of children. Preble echoes an oft-repeated theme in stating that 'the mother is the primary provider for children in African culture...and even if the father survives the mother's

HIV/AIDS death, experience with child care in Africa suggests that children do not usually receive sufficient care from their fathers alone' (1990: 674).

Despite this reification of the role of the mother in Malawi (and Africa in general), in the current context many of the daily caretaking activities that Westerners associate with mothers are carried out by other children. Thus, in many instances it is siblings who provide a 'mothering' role within a family, and mothers who provide the economic support necessary for this care. Mothers are responsible for providing food and clothing for children. Generally this involves doing the necessary farming and trading required to secure provisions and sufficient money to buy new *chitenje* and other items of clothing for the family. Siblings, however, usually ensure that children in their care are clean, kept entertained, calmed when upset, and protected from harm.

Being a mother is, however, still considered an important role in Malawi and is also one that most women adopt automatically – it is simply an expectation that they fulfil. In their article 'Women's Fears and Men's Anxieties: The impact of family planning on gender relations in Northern Ghana', Bawah *et al.* (1999) point out that the payment of bridewealth signifies a woman's requirement to have children. While I was in Malawi, a Malawian friend, Rachel, married a German living in Zomba. Rachel was a widow and had three children from her first marriage. In the negotiations for *lobola* (bride price) the groom was told that his bride-to-be had '*proven herself as a woman. This is why you must pay more for her.*'

Anthropological studies have often highlighted the difference between the 'ideal' and the 'real'. Discussions regarding the influence of the researcher on impression management by respondents are common (Hammersley and Atkinson, 1996). Based on Weber's (1949) concept of the *ideal type*, it is a recognized hazard of research that what informants state as truth is not necessarily what occurs. For ideological reasons they may emphasise traditions rather than actual practice, or vice versa. The discourse is not, however, necessarily wrong. That a mother in Malawian society is important is demonstrable on many levels, and the fact that her children also

participate in mothering each other does not demean this. The role of siblings is discussed further in a later section.

The social construction of the role of 'mother' is obvious in Malawi. A key illustration of this is provided by the conflicts over mothering that occur between expatriate mothers and their maids who are often involved in child care. Cathy, an American, had her first child three months after moving to Malawi. Based on the way that she herself had been raised, as well as advice from child-care literature she had brought with her from the US, she had a very strong sense of what appropriate care for an infant should consist. In a subsequent discussion on the topic of how Malawians lifted up their children, she expressed horror at the cavalier way in which Malawians grabbed infants and children by one arm and swung them around '*risking a shoulder dislocation!*' I, too, had been taken aback by this technique the first time I had witnessed it during my first week in Malawi. Cathy's and my experience of the discourse surrounding infant handling emphasises the frailty of babies: one is instructed to adequately support the head and neck at all times, lift gently, and generally take extreme care in handling them. The nannies at OA and Cathy's maid, Nora, laughed at our shock at local practice – I was told by one nanny '*don't worry, they do not break*'.

Another example of differing views is the question of whether or not to pick up a crying baby. Initial observations at OA emphasised the fact that Malawian women do not respond to a baby's cries with any promptness. I assumed that this was because the carers, being unrelated to the infants in their charge, were not prepared to invest emotionally in their wellbeing. Being a nanny in an infant home where there were numerous crying babies was merely a job. Babies who were obviously crying from hunger or because of a dirty diaper were ignored for extended periods of time. This observation was reiterated in Zomba, in the activities of my neighbours (with two infants in the house), and numerous times while conducting interviews in villages. In these latter instances it would be a sibling who would respond and do the necessary to quieten the baby down, unless it was hungry in which case it would continue crying and eventually the mother would reach for it and start breastfeeding. When I

asked women why they didn't respond to the baby's cries they merely shrugged and, by the way they looked at me, I could tell that they considered me stupid for asking such a question: there was simply no need to respond immediately. If the baby were genuinely hungry s/he would continue crying and would get fed; otherwise the crying would eventually stop.

Cathy, on the other hand, would immediately respond to her daughter Elise's cries in all circumstances bar one – that of establishing a regular sleep pattern. When she put Elise down to sleep she would ignore any crying for an extended period of time. If Elise failed to fall asleep, though, Cathy would eventually pick her up. Nora, on the other hand, despite instructions from Cathy to the contrary, would insist on picking the baby up and carrying her around, strapped on her back in a *chitenje,* to quieten her down. Though I'd never observed Nora with an infant of her own (her daughter was seven years old) I suspect that she would have behaved like all the other Malawian mothers I observed in villages and allowed her own child to continue crying for a long while. Yet, in the context of her employment by an expatriate family, her idea of what constituted good infant care changed, and was influenced by her perception of how *azungu* treated their children. Thus, Nora had noted that Cathy and other *azungu* mothers responded promptly to the cries of their children, and she adopted this behaviour when dealing with their children. The contextual nature of such behaviour illustrates how the ideal of mothering is socially constructed.

Cathy's and my understanding of children as frail beings is rooted in Western economic prosperity that allows women to dedicate time to child rearing. Definitions of mothers arose simultaneously with an emphasis on social childhood. 'Childhood came to be seen as a special and valued period of life, and children were depicted as innocent beings in need of prolonged protection and care. This new conception of childhood required a complementary conception of motherhood as a serious responsibility, one that required total and exclusive devotion' (Glenn, 1994: 14). Glenn points out that African-Americans escaped this conviction of the nature of childhood and the concomitant role of the woman since they, like other ethnic minorities in the US, did not have the same separation between public and private

spheres of life, nor did they have the same economic prosperity. Women of these groups were often required to contribute financially to the family by going out to work, similar to the situation evident in Malawi at present. Instead, mothering is understood by African-Americans as not being limited to the biological mother. Definitions of what acts constitute appropriate mothering differ between ethnic groups in the US. For example, 'Segura found that Mexicans think of providing economically for their children as intrinsic to mothering, while Chicanas have internalized white, middle-class, U.S. ideology that categorizes employment as oppositional to mothering' (ibid. 16).

The role of the mother in rural families in Malawi is shaped within a context of extreme poverty and hardship and is necessarily understood to be that of a provider. Without the luxury of time and money, Malawians cannot dedicate themselves to caring for their children in the same way as many Westerners do. This is not to say that Malawian childcare is in any way inferior to our own, it is simply different.

The difficulty of providing for children and ensuring their survival is intrinsically influenced by the many exigencies with which rural women are continuously confronted. This is reflected in the high infant mortality rates in Malawi. Nancy Scheper-Hughes argues that:

> ...a high expectancy of child death is a powerful shaper of maternal thinking and practice as evidenced, in particular, in delayed attachment to infants sometimes thought of as temporary household 'visitors'. This detachment can be mortal at times, contributing to the severe neglect of certain infants and to a 'failure' to mourn the death of very young babies. I am not arguing that mother love, as we understand it, is deficient or absent in this threatened little human community but rather that its life history, its course, is different, shaped by overwhelming economic and cultural constraints. (1992: 340-1)

While she is citing her fieldwork experiences in Brazil, much of this is true also for Malawians. Infants are not mourned in the same fashion as are adults and, though their death provokes an emotional response, this response is clearly delineated and differentiated from that resulting from adult deaths. Though discussed further in the

following chapter, this is mentioned here in order to highlight the fact that mothers in Malawi have developed protective mechanisms that ensure that they are more able to continue providing for their families in the wake of a child's death.

The role of the father

Given that the purpose of this thesis is to examine the impact of a mother's death on her family and community, my research into the role of fathers within a family is somewhat limited. I interviewed several men who were caring for orphans in a variety of contexts: in some instances they were looking after their own children, in others they were looking after their sister's children or their orphaned siblings. My choice of focusing on the death of a mother was informed by many references to the increased risk to children in Africa brought about by their mother's death than would ensue should their father die. Women are cited as being more likely to spend earned income on their families, as opposed to themselves, than are men (e.g. IFAD, 1985; FAO, 1998). They are also seen as having the key responsibility for the care of children, as discussed in the previous section. While my observations confirmed many of these stereotypes, this does not mean that the father is of no import in the Malawian family.

In literature on reproductive health and sexuality, the African male is often portrayed in a highly negative fashion. Historically, this literature has focused on women's use of contraceptives and portrayed men as impediments to women's abilities to utilize these. An example of this portrayal is provided by Maharaj in an article on 'Male Attitudes to Family Planning in the Era of HIV/AIDS: Evidence from KwaZulu-Natal, South Africa', which concludes that men interpret condom use 'as a clear sign of infidelity or lack of trust and the perceived emotional benefits of unprotected sex may be seen as more important than the risk of STDs/HIV.' (2001: 256). Furthermore, 'many men feel that the payment of bride wealth entitled them to demand sex whenever they desire. If the wife refuses, the implication was that the man has the right to force intercourse with her.... For many men, violence is seen as a natural part of the sexual relationship.... In some instances, male violence was interpreted as indicative of affection or commitment' (ibid. 257). The author does

state, however, that there is an increasing demand from men for condoms to protect themselves against HIV/AIDS, despite these commonly held beliefs.

The impression one derives of African men from much of the literature on reproductive health is that they share little in the daily care of children and that, to a considerable degree, they are emotionally uninvolved with these children. Experience in Malawi both confirms some of these issues and lessens this negative portrayal of African men. It must be emphasised that a father's relationship with his children does not necessarily end when he no longer has contact with them on a daily basis. Should he leave the children in the care of their maternal relatives (often in order for him to re-marry), he may still contribute financially to the upkeep of his children whenever possible. Furthermore, they may be able to use him as a resource when they are older and in search of jobs. This practical help is much valued by children and, along with the receiving of gifts from their father, is a means by which they understand they are 'loved' by him.

Often, however, men tend to be more involved with the care of their sister's children than with their own. This is due to the matrilineal nature of the society under study. When a woman dies her children remain members of her lineage and, usually, this dictates their place of residence. In some instances, a father may choose to take some older children with him when he leaves the village, usually in order to have them share the burden of caring for a sister's orphans. More often than not, though, they are re-absorbed into their mother's lineage and provide assistance to their female kin. Margaret Austin discusses her role of caregiver of some of her sister's children. Two of her sister's sons had gone with their father to Blantyre, where they were working with him 'doing business'.

> Question: Are the children living with their father older than these living with you?
>
> *Margaret: Yes, they're older.*
>
> Question: So does the age of the children make a difference as to where they stay after their mother's death?

Margaret: It's their father who said I have to take some of the children just because I was just staying.

Question: So how did they decide that those children should go with their father and these stay here?

Margaret: I choose children which are very young just because I am having others which can be playing with them.

Question: Did you choose whether to take boys or girls?

Margaret: I just choose young ones because [they require more care from their mother] than father so being a mother I take these so that they shouldn't be remembering their mother.

In this example, a woman is looking after some of her sister's children, while their father takes care of the older ones. A division of responsibility, which benefits the orphans, is thus created between the maternal relatives and the father: the older children gain access to the employment market while the younger ones are provided with a surrogate mother. The children's father is actively involved in ensuring the children's wellbeing, but he is not the only male who participates in this endeavour. Margaret's husband also provides substantial assistance by sharing his household and wages with his sister-in-law's orphans. This he does within a context of reciprocal care and assistance by kin. Margaret acknowledged this:

Question: What about your husband, did he say anything about this?

Margaret: He doesn't say anything, as he knows that I was also cared for by my brother. My mother died whilst I was young....

Thus Margaret, with the support of her husband, is contributing to the kin network that supports relatives in their time of need. She had benefited from this provision of assistance while growing up and is now returning the favour to the group as a whole.

Fathers usually provide assistance to their children for a limited period after the mother dies. The most common factor that causes the cessation of assistance is the re-marriage of the father. Irene, a twelve-year-old orphan, pointed out that her father

left her in the care of her aunt (ostensibly giving her a choice, though there were no other alternatives) in order to re-marry.

Question: Is your father still alive?

Irene: Still and he is at his home.

Question: What does he do?

Irene: Nothing, he is just staying.

Question: Why didn't you live with him?

Irene: Because he left us before Mother's death.

Question: Do you have choice about where to stay?

Irene: We were given a chance, so we choose to stay with our Aunt.

Question: Why did you choose your Aunt?

Irene: Just because she has been caring for us whilst our mother was alive.

Question: Who gave you a choice about where to stay?

Irene: Our father.

Question: What did he say?

Irene: We can choose where to stay....He said, 'he cannot live with us but choose someone to live with'.

Question: Is your father married?

Irene: Yes.

Question: Do they have children?

Irene: No.

Question: Do you think that your father does not want to stay with you because of this marriage?

Irene: Yes.

One father explained to me why his children were no longer living with him, subsequent to his wife's death. He highlighted the fact that poverty often prevents men from playing an active role in caring for children who are living at a distance with their mother's relatives.

Damiano: My wife [wasn't sick for a] long time. She went to the market where she met a friend so they sat down under a tree to chat and unfortunately on the spot she started vomiting blood until when she was taken to the hospital where she died.

Question: Are [the children] experiencing problems because they don't have a mother?

Damiano: Yes, as most of the relatives who were to keep them died and also I am poor that I am not helping them anymore since they are living in Ntanja.

Question: When did the children move to Ntanja?

Damiano: The day we went to bury my wife.

Question: Who made the decision that the children should stay there?

Damiano: Its our custom whenever a wife dies the children don't go with the father and after his wife's death his in-laws permit him to be going to visit the children.

Question: Do you contribute on caring for the children?

Damiano: I am supposed to be going and I have been going but I am not due to lack of money.

Question: Does your wife's family expect you to go there?

Damiano: Yes.

Question: How do children feel about leaving to [live in] Ntanja?

Damiano: This did not make them happy.

Malinowski, in his book *The Sexual Life of Savages* (1932 [1987]), claims that fatherhood among the Trobriand Islanders has an exclusively social meaning, but one that provokes a degree of social tension. While the child is growing up, the 'father' (mother's husband) shows affection and offers protection to the child but the older the child gets the more it is incorporated into the mother's lineage and is distanced from the father. This duality creates many tensions, since affection and duty are at war with each other in the father, who will be incorporating the children of his sisters simultaneous to the distancing of the children he has raised. This echoes many of the problems experienced by fathers in Malawi, who may be prevented from taking as

active a role as they would like in caring for their children after their wife's death. Traditional rules of residence for orphaned children, as well as extreme poverty which usually requires male migration in search of employment, play a significant role in limiting the role of the father in Malawian families.

Despite this more limited role, however, fathers are honoured and revered in public discourse. When I initiated contact with Mr Mpoya, the gatekeeper for the Songani community, I explained the purpose of my research and outlined the criteria of selection for interviewees. Despite this explanation, however, there were many occasions when he would suggest I interview a particular individual because she had lost her husband and was suffering terribly. For much of the period of my fieldwork I sensed that there were continuous attempts to steer my research towards examining those families where the father, rather than the mother, had died. The experience for these women, who often have to suffer the extensive loss of possessions 'grabbed' by the husband's relatives, as well as the possibility of loss of inheritance to one of the husband's brothers, is indeed harrowing. Examination of this phenomenon, however, was not the goal of my research, and having people try to guide me in that direction raised questions. Perhaps, to some extent, the reason that people tried to influence my research in this way had to do with Malawian gender relations. The importance of men in society is emphasized more than that of women. My focus on women, therefore, was potentially upsetting in that it contradicted the supremacy of men. The death of a woman, however, usually effectively meant that children lost both parents and were thus more vulnerable than in those instances where the father died but the mother remained as prime caregiver.

Definitions of 'orphans'

Despite concern over increasing orphan numbers, there has been no critical examination of local understandings of orphanhood. This section analyses the category of 'orphan' as it appears in literature both in Malawi and internationally. It juxtaposes this with information drawn from case studies and participant observation which highlight emic definitions of 'orphan'. By comprehending how 'orphans' and

'orphanhood' are defined and experienced by the communities under observation, an understanding of how they evaluate the impact of a mother's death is furthered.

The most frequently cited definition of an orphan in Malawi is 'a child under the age of 18 who has lost a mother' (e.g. National Economic Council of Malawi, 2000; Rais, 2002: 3), a definition which highlights the primacy of the role of the mother in providing care for children. This definition also echoes the matrilineal nature of a large proportion of Malawian society under which traditional rules a child belongs to the lineage of his/her mother. Furthermore, it reflects the economic realities of a country like Malawi, where men provide a source of migrant labour throughout the country and, indeed, the region. Malawians are heavily represented on the mines in South Africa, for example.

This definition of an orphan was revised, however, in the mid-1990s – to little effect, however, since many recent publications still cite the original definition. Policy guidelines for the care of orphans in Malawi now define an orphan as 'a child under the age 18, one or both of whose parents are dead.' (Donahue and Williamson, 1996: 2). These authors point out, however, that estimates of numbers of AIDS orphans are generally only made for maternal orphans. This is partly because maternal demographic data is more readily accessible, but also to recent emphasis and acknowledgment of the role of a mother as the key caregiver (Foster and Williamson, 2000: 275).

UNAIDS has two designations for orphans, including 'a child under 15 years of age who has lost their mother (maternal orphan) or both parents (double orphan) to AIDS' (Phiri and Webb, 2002: 5). No mention is made of children who only lose a father. These classifications also exclude orphans between the ages of 15 and 18 and, importantly, those orphans who have lost a parent to a cause other than AIDS. Even with this restricted definition of orphans, however, UNAIDS estimates that by the year 2010 there will be 24.3 million orphans in sub-Saharan Africa (ibid.). Foster and Williamson (op. cit.) point out that definitions which exclude paternal orphans underestimate the problem by 45-70%, and those which exclude the age range 15-18

underestimate by 25-35%. The varying age rates in characterizations of orphans are a result of the fact that child health surveys collect data on children under the age of 15, but the Children's Rights movement emphasizes that children deserve to be acknowledged as such until the age of 18 (ibid.).

To widen the problem of orphans even further, Bradshaw *et al.* highlight the problem of examining only those children whose parents are actually dead when evaluating the impact of AIDS orphans on communities. They maintain that:

> orphanhood may in practice begin long before the death of a parent. This will happen where there is a sole parent and that parent becomes sick with AIDS. Often the household is without income and the parent is no longer able to support the child. This and the trauma of watching the parent slowly dying are the first stresses the orphan has to face. (n.d.: 1)

In a situation where a large number of children are living with HIV-infected parents, drawing attention to these children highlights the future impact of orphanhood on communities.

It should be noted that none of these descriptions of orphans account for those children who have lost foster parents – members of their extended family who were their prime caregivers, a loss which can be as grave as the loss of a natal parent. Children become 'uncommonly familiar with death' because 'when they become orphans, they go to their grandparents or to another relative. An aunt or uncle may also die of HIV/AIDS or a grandparent from old age. Double or even triple orphaning is not unknown.' (Barnett and Whiteside, 2002: 17).

Furthermore, these characterizations of orphans fail to differentiate between the varying needs of different age groups. For example, 'defining orphans as children under 15 years detracts attention from the needs of older adolescents including the sexual and economic exploitation of adolescent girls' (Foster and Williamson, op. cit.). As a result of these various issues with the category of 'orphans', many development programmes now refer to a category of 'orphans and vulnerable

children (OVC)', which includes those children who are at risk due to HIV/AIDS and high death rates in their communities.

Many 'adults' over the age of eighteen still defined themselves in conversations with me as orphans, since they were unmarried and therefore weren't seen as adults by members of their community. In many respects, therefore, the category of 'orphan' is synonymous with 'child' and it is only when a person becomes an adult (i.e. gets married) that they are no longer an orphan. The fact that these individuals are classified as orphans, socially but not officially, means that their viewpoints and needs are not being addressed by orphan initiatives.

Finally, orphans themselves may not define themselves as such simply because of their age or because they have lost a parent. Khomeini is a nine-year-old boy living with his grandmother. He is the youngest of three orphans. His older sister lives with him, but his older brother lives and works in Blantyre with an uncle. The following interview extract explains why he classifies himself as an orphan:

Question: Khomeini, do you see yourself as an orphan?

Khomeini: Yes.

Question: Why?

Khomeini: Maybe it's because of Spirits.

Question: What do you mean?

Khomeini: Usually when I am moving along the cemetery, I hear my name being called, but when I respond, I don't see who was calling me. So my granny advised me never to respond again, I think this is because I am the youngest.

Question: Meaning to say, if you were to be older, this could not happen to *you?*

Khomeini: Yes.

Question: What do you feel it's like?

Khomeini: I feel like they are calling me to death.

Question: So how do you feel about this?

Khomeini: I am warned.

***

Question: How are you going to deal with it?

Khomeini: I think praying hard can help.

Question: Do you think the Spirits are speaking to you because you are an orphan?

Khomeini: I think so.

While Khomeini was the only orphan to provide an answer of this kind, it serves to illustrate the complexity of the concept of 'orphan'. Khomeini's susceptibility to seeing and hearing spirits is what makes his status as an orphan real to him, yet this would not feature in any official description of 'orphanhood'. Despite being twenty four years old and the primary caregiver for his siblings, another case-study individual, Ignazio, is also described by himself and others as an orphan. This is partly explained by his single status. He has not yet become an adult in the eyes of his community and, therefore, can be categorized together with orphaned children regardless of his roles and responsibilities in everyday life. Yet he too falls outside of official definitions of 'orphans', which assign strict age limits to experiences of vulnerability.

There is a very clear political dimension to the choice of defining an orphan. Whichever characterization is chosen has clear implications for the selection of case studies/interview respondents as well as for the figures one cites regarding the number of orphans. This study cites several figures for the number of AIDS orphans in later chapters and, where the definition was made explicit in the original documentation, it is herewith noted. Obviously, for the purpose of selecting case studies, the death of a mother was a prerequisite for this research. Many of the case studies, however, are of children who are double orphans. Moreover, there is a very strong possibility that since the completion of my fieldwork some of the orphans included in this study have lost their foster parent. Given that some of the caregivers I interviewed were very sickly, some possibly with AIDS, and the impact of the

famine in Malawi, it would be surprising if some of the orphans have not experienced the tragic loss of yet another caregiver.

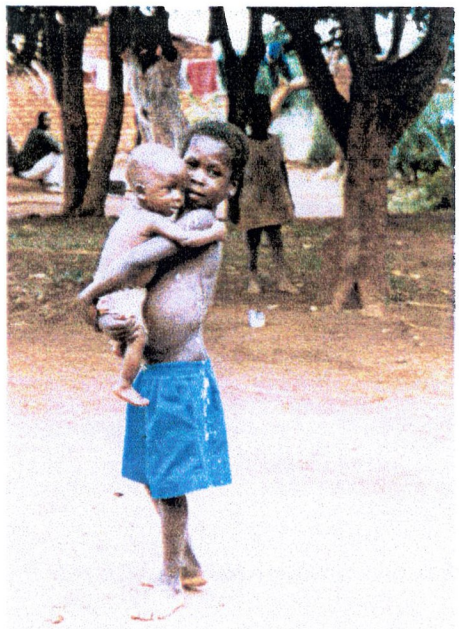
Patterns of sibling care

The role of siblings in caring for each other struck me early on in my fieldwork. I had gone to visit the household of a family whose son had been at the Open Arms Infant Home (OA) in Blantyre. Benjamin had been returned to his family three months previously, and a member of staff from OA who was worried about him (he had been very sickly) requested a lift to go and visit him. We arrived mid-morning in the village, and after several inquiries located the house. Benjamin was there with two older brothers, aged six and eight respectively (Benjamin was two-years-old at the time). We were told that their father was 'away' and that their grandmother was working in the field. A neighbour offered to go and fetch her, and while we waited we chatted with the young boys. Benjamin was very, very shy, and cried every time Ingrid or I approached him. Whenever he would start to cry his six-year-old brother would pick him up and hold him while talking to us. Both brothers were very amused at his reaction to us. They would tease him by holding him out to us so that he would get scared and start crying. The six-year-old would then pull him back and 'shush' (*pepa, pepa*) him until he calmed down. When the grandmother returned she completely ignored Benjamin's cries, and he remained either hiding behind his brothers or in a brother's arms.

Observations similar to this were repeated countless times, whenever I visited people in their homes in the village and with my own neighbours. Crying children would elicit no reaction from their mothers, unless they were still breastfeeding, in which case they would be given a breast. If the baby would not feed, another child would come and take the child away from the mother and just hold it. Siblings would apparently pair up, each looking after the child closest in age, though sometimes an older sibling would take on a 'mothering' role with the youngest as well. Malawians often identify the sibling they are closest to when discussing their families. It is a relationship that persists well into adulthood. This 'mothering' role assumed by children is not limited to girls; children of either sex will assume the responsibility

for caring for a younger sibling, and do so with a combination of pragmatism and tenderness.

The young boy, Felix, pictured in this photograph, had brought his younger brother



over to his mother, Linly, whom I was interviewing at the time. The baby had been crying for some time and Linly breastfed him for a while. She then handed him back to Felix, who proceeded to burp him. Felix carried him around and played with him for the rest of the visit.

Robin Fox pointed out that in a matrilineage 'the essential bond is that between brothers and sisters, because the children of the sisters are the men's heirs and successors' (1967: 104), an observation in agreement with Malinowski's work with the Trobrianders, among others. Carsten (1997) also emphasises the centrality of siblingship based on her work with the Malay, attributing it to a variety of factors, including historical myths and modern residence patterns. I believe that, within the Malawian context, the framework of extreme poverty in which family relations are formed underpins the close relationship between siblings. Unlike the Malay, Malawians do not frame their kinship structures in terms of sibling relations, and the observed closeness between siblings does not receive ideological reinforcement or encouragement. In reality, quite the opposite occurs since the importance of sibling bonds is subsumed in favour of maintaining the image of a mother caring for her children with the (predominantly) economic assistance of her husband. Children's role as caregivers does not enter this idealized picture.

The sibling bonds that emerge in childhood remain throughout adulthood, usually until death. This is particularly true of sisters since, due to the matrilineal nature of the society, they can establish households in close proximity to each other and build

on the relationship established in childhood. Women choose to live closest to the sister to whom they have the most emotional commitment and, as I observed during my fieldwork, the two households often effectively operate as a single unit. Agricultural activities are shared, as are childcare duties and household work. Thus, when one of these sisters dies, the remaining orphans are incorporated into a family with which they already have extensive ties. As discussed further in Chapters 5 and 6, the decision as to which family member becomes the orphan's primary caregiver is usually unarticulated since the close relationship between two particular sisters (and their households) makes the outcome a foregone conclusion. Thus, sibling pairs established in childhood remain an important factor in adulthood and inform to some degree the coping mechanisms employed by kin subsequent to a mother's death.

Conclusion: Kin/community response to a mother's death

This chapter has demonstrated the key role that kin play in looking after orphaned children subsequent to their mother's death. It is important to highlight the fact that official definitions of orphans do not necessarily reflect the experiences of communities in this regard. Orphanhood is not a clearly defined condition. This has implications for policy responses to the phenomenon (see Chapters 6 and 7). The key issues to emerge from the research presented in this chapter, and ones that are crucial to the analyses in subsequent ones, are the convergence of the categories of 'kin' and 'community', and the importance of sibling bonds. This convergence highlights the fact that a mother's death does not only have ramifications for her children, but is felt on a much wider scale. At the same time, the sibling bonds formed in childhood influence decisions over who will assume responsibility for the care of orphans upon the death of a mother.

My findings also demonstrate that a mother's death results in the break-up of her family unit, and the formation of a new household as orphaned children are incorporated into their maternal kin's families. This conclusion is key to analyzing the impact a mother's death has on kin and community, and is expanded upon in the following chapters.

The following chapter will introduce a discussion on HIV/AIDS, which is a major contributing factor to increased adult death rates and numbers of orphans. This is followed by an analysis of community responses to death, a description of funerary rituals and case-study examples of how families cope with the immediate aftermath of a mother's death.

CHAPTER 4: HIV/AIDS

The previous chapter introduced the reality that HIV/AIDS is a major factor in the increasing number of orphans in Malawi. This chapter, therefore, presents information about the HIV/AIDS epidemic in Malawi gained from both fieldwork and literature reviews in order to provide background information for subsequent chapters that deal with theories and understandings of: (i) death, including curtailment of death rituals (Chapter 5); (ii) community responses to orphan care (Chapter 6); and (iii) external initiatives aimed at caring for orphans (Chapter 7).

The primary reason for including a discussion of HIV/AIDS is its prevalence in Malawi. It is estimated that approximately a third of the population is infected with HIV (UNAIDS, 2000*a*; Malawi Demographic and Health Survey, 2000). While infant and early childhood mortality rates have been slowly decreasing over the past two decades, there is a striking increase in adult mortality, particularly female mortality. The Malawi Demographic and Health Survey points out that since the early 1980s there has been a 74% increase in 'all-case adult female mortality for the age group 15-49' (2000: 179). This increase is related to the HIV/AIDS epidemic and is key to this analysis of the impact of a mother's death on kin and community. Through an understanding of the manifestation of the HIV/AIDS epidemic in Malawi, the complexity of the ramifications of a mother's death can be further explicated. HIV/AIDS is directly responsible for increasing the frequency of such deaths, while at the same time it is taking its toll on the adult population in general. Many individuals who aren't infected are caring for the orphans of those who died of AIDS-related causes for example, or else for someone who is sick with AIDS. It is crucial to understand that HIV/AIDS has an impact on all aspects of society and thus plays a significant role in undermining the coping mechanisms of kin and communities which would otherwise respond effectively to the aftermath of a mother's death.

In this chapter I describe the discourse around HIV/AIDS at national level including the manner in which it is addressed by the national media. I also explore how individuals within the fieldwork area have responded to this epidemic.

Characteristics of the HIV/AIDS epidemic in Malawi

In order to fully understand why increasing numbers of maternal deaths are such a threat to Malawian social structures, it is necessary to grasp the full scale of the HIV/AIDS epidemic in Malawi. To say that this disease impacts on every aspect of daily life is no exaggeration, and its associated morbidity and mortality rates are largely responsible for the undermining of traditional methods of coping with a mother's death and the remaining orphans.

The existence of HIV/AIDS in Malawi was officially denied until President Banda resigned in 1993, by which time the disease had fully taken hold within the country. Poverty and women's marginal status play important roles in the perpetuation of the disease; reduced economic power promotes commercial sex work and other high-risk behaviours, while also limiting access to condoms. The various responses to the epidemic include health-awareness campaigns and the promotion of abstinence by faith communities. There has also been an attempt to address some of the cultural practices, such as female initiation rites, that promote the spread of the virus. Recent legislation is aimed at punishing those associated with its spread. President Bakili Muluzi, for example, has ordered that commercial sex workers and their clients be arrested on sight in an effort to slow down the progress of AIDS (Tenthani, 2000[7]); the effectiveness of this measure was called into question when the number of prostitutes in Blantyre increased dramatically during the meeting of Heads of State of the Southern African Development Community (SADC) (BBC Monitoring, 2001[8]). On 11 September 2000, the African Newswire Network also reported that Malawi's Law Commission is to review the country's penal code to make the deliberate spreading of HIV a criminal offence. The new law would criminalize unprotected

[7] http://news.bbc.co.uk/1/hi/world/africa/852920.stm

[8] http://news.bbc.co.uk/1/hi/world/africa/1484675.stm

sex between people who knew they had the virus, a move welcomed by women's groups though they caution the difficulty in proving such cases. It is thought that this law will affect many husbands who contract the virus through extra-marital affairs and then infect their spouses.

A brief overview of some of the statistics representing the HIV/AIDS epidemic in Malawi can highlight its impact. UNAIDS (2002: 2) states that by the end of 2001, in Malawi's population of 11.57 million people there were 880 000 adults and children living with HIV. During 2001 there were 80 000 deaths due to AIDS and by the end of 2001 there were 470 000 orphans under the age of 15 who had lost either a mother, father or both parents. These figures are not uniformly distributed around the country, however, and the regions where this research took place are disproportionately affected by the epidemic, with approximately a third of the population infected with the disease (World Bank/Government of Malawi, 1998: 6).

The impact of HIV/AIDS can be felt at every level of society. Education is affected because teachers are succumbing to the epidemic (Davison and Kanyuka, 1990; McBride, 2001). HIV-positive teachers who have sex with female students endanger the health of young women. Munthali claims that 'Aids kills one student of the University of Malawi every week' (2001: 2), adding that 'no one has had the courage to disclose causes of such deaths.' (ibid.).

Household survival strategies are jeopardized because the agricultural sector is profoundly affected. IFAD, for example, states in its *Strategy Paper on HIV/AIDS for East and Southern Africa* that:

> The epidemic has caused the decimation of skilled and unskilled agricultural labour; a steep reduction in smallholder agricultural production; a decline in commercial agriculture; the loss of indigenous farming methods, inter-generational knowledge and specialized skills and practices; and capacity erosion and disruption in the service delivery of formal and informal rural institutions resulting from the scale of staff morbidity and mortality (2001: iv).

Households' ability to cope is increasingly put under strain. As I observed, women,

who function as primary caregivers of the sick, must dedicate more and more time to this task, often to the detriment of input provided to children's care and agricultural work (in line with observations by Maposhere, 2001; Nelson, 2002). Women are also particularly vulnerable to contracting HIV for both physiological and social reasons (Bisika, 1995; Ackerman and de Klerk, 2002; and Buseh *et al.,* 2002). Social factors that increase women's risk of HIV/AIDS infection include violence against women, their unfavourable economic position, and male control of sexuality (including women's lack of control over the sexual lives of their partners and their inability to insist on condom usage) (Ackerman and de Klerk, 2002: 166). Men and women do not discuss sex with each other, nor do parents discuss issues of sex and sexuality in front of children – an issue that affected many of my interviews, since it required children being sent away out of earshot of our discussions. Many female deaths can likely be attributed to AIDS, though, due to a lack of testing facilities and poor record keeping in hospitals, this can not be determined with any certainty. Several of my case-study families attributed the death of their daughter/sister to AIDS, in some instances based on test results proving that the person in question had been HIV positive. Many of these people reported negative reactions from others within their communities to their frank discussions about HIV, reflecting the stigma associated with an HIV positive status.

The main barriers to preventing the spread of HIV/AIDS continue to be a lack of education about the causes of the disease, and a dearth of effective treatment options. The latter is linked to people's fears of discovering/disclosing their HIV status. I encountered widespread misapprehensions about the cause and nature of the disease, indicating that there is a general lack of understanding about the realities of living with HIV/AIDS. For those who have been tested and who are faced with the fact that they are HIV positive, therefore, there is often a problem of being ostracized from their communities; many are reluctant, therefore, to reveal their status. The lack of communication between those living with the disease and those who are healthy, or unaware of their HIV-status, was demonstrated by the fact that many of the HIV-positive people I interviewed had not informed their families of their diagnosis. This compounds the problem of a lack of realistic understanding about coping with

HIV/AIDS. An insight into the knowledge of and attitudes towards HIV/AIDS held by many in the research area, and an examination of the lifestyle of some individuals who are living with the disease, follows. This serves to provide an indication of why AIDS-related maternal deaths and AIDS orphans are issues of increasing concern.

HIV/AIDS in the media

Frequently, there are articles about various aspects of HIV/AIDS in the media in Malawi. Examples include an article on the impact of HIV/AIDS on the university community (Musukwa, 2001: 2), and another reporting on government initiatives to provide free school to orphans (K. Munthali, 2001: 1) and nevirapine to pregnant and nursing mothers (Inter Press Service, 2001: 20). This reporting, however, does not examine these issues in depth, and goes hand in hand with many unexamined attitudes towards HIV/AIDS that are potentially damaging. For example, students at the University of Malawi are characterized as contracting HIV/AIDS as a result of 'heavy drinking and 'falling in love carelessly'' (K. Munthali, 2001: 2). Youths are called upon to 'shun sexual immorality' and 'stop experimenting about sex to avoid contracting Aids' (Musukwa, 2001: 3). Unequal power relations during sexual negotiations are not mentioned. Predation by teachers on their female students is a common occurrence at the university, and one that is matter-of-factly accepted, as the following incident demonstrates.

> Martin is a young, expatriate lecturer at Chancellor College. He arrived here straight out of university and this, combined with the fact that he is new to Malawi, has led to some of his colleagues providing advice on how to effectively do his job. One of the first discussions he had was with his head of department who told him 'if there is a girl you would like to sleep with, you must give her a mark just below a [grade] boundary. Then she will sleep with you to get the good mark.'. In recounting this event to me Martin was horrified: 'I think I was initially more shocked by the fact that he was ok about telling me this, he didn't even whisper it, he just said it. Like it's completely ok, everyone does it, and you need sex, right?'.

In the social research literature this phenomena is highlighted frequently (e.g. Davison and Kanyuka, 1994; Malawi National Safe Motherhood Programme, January 1995; National Family Welfare Council of Malawi, 1996; Hickey, 1999) and is identified as being an issue of major concern, yet this concern is not reflected in the popular press. Unequal gender relations are not linked to the HIV/AIDS epidemic, either, and newspapers often reinforce such power discrepancies. Characterizations of women as sexually promiscuous are found in articles, but it is the weekly *Zabweka* cartoon that illustrates this most powerfully. Every week, without fail, the character Zabweka falls prey to the promiscuity of women. The example provided below is typical.

FIGURE 7: ZABWEKA, THE NATION 24 JANUARY 2002

Unequal gender relations have been discussed previously and it is important to note that stereotypes such as those demonstrated in these cartoons are commonplace within Malawian society. Crucially, these stereotypes are not harmless; they have a direct impact on women's ability to protect themselves during sexual intercourse, and hence protect themselves from sexually transmitted infections (STIs), including HIV. Gender relations are a significant factor in women's deaths in Malawi. Their

inability to insist on adequate health care (because women don't necessarily control the financial resources they contribute to the family) combined with their physical and social vulnerability to STIs and HIV/AIDS, mean that women's health is severely compromised.

Radio broadcasts, which are more accessible to the general population than is the print medium, frequently mention the threat of *edzi* and run advertisements for *Chishango* (the local brand of condoms). Reproductive health NGOs such as Banja la Mtsogolo (a local 'family planning' clinic) and Population Plan International (PPI) sponsor plays, which are broadcast on the radio, and provide educational slots which promote HIV/AIDS awareness. My research assistant, Fadi, told me that girls at her school listened to these programmes religiously, and that the programmes went much further in examining the epidemic than did the newspapers. She had, for example, heard a debate about what punishment was appropriate for male teachers who had sex with their students. As is discussed in the following section, the vast majority of people I met had some information about HIV/AIDS and had some idea of its impact on communities. Much remains to be done, however, in aiding people to examine cultural practices and gender stereotypes that contribute to the spread of the disease.

Knowledge and attitudes regarding HIV/AIDS

The initial set of interview questions administered to case studies included a number of questions on HIV and AIDS. Interviewees were asked, for example, to define HIV and AIDS, to say if they knew of anyone suffering from such a disease, and to comment on whether or not people who were HIV positive were treated any differently in life and/or death.

Before developing the questionnaire, I had experience of talking to traders in Blantyre who followed South African President Thabo Mbeki's belief that HIV and AIDS are unrelated. Therefore, when I asked people about HIV and AIDS it was as two separate entities. When translated into Chichewa, 'HIV' (pronounced as in English) and 'edzi', (sometimes used in Chichewa to indicate the HIV virus as well as the associated disease of AIDS) were queried.

HIV was variously described in interviews as follows:

Irene: It's a deadly disease.

Linly: HIV is a disease which destroys the immune system contracted by a man who sleeps with someone who has it.

Margaret: I only heard from the radio that it's a sexually transmitted disease,

Edith: I don't know but I heard that it's a germ.

Gladys: AIDS is a disease which has just come in and in our days there was not such a virus, it can be contracted by a man who is moving with other women and can pass to his wife. If the wife was pregnant, the foetus can be affected too. She can deliver well, but the baby might be weak and it can increase the virus through sucking.

Lonnie: It is a disease. I don't know more than this.

Ignazio: HIV is a virus that starts a deadly disease called AIDS.

AIDS was further explained as:

Catherine: AIDS is a viral disease that weakens and destroys the immune system of the body.

Lonnie: It is a disease which have some effects with it like having Malaria, your body becomes very thin.

Samuel: AIDS and HIV are the same.

Margaret: AIDS is a disease which is transmitted through sexual intercourse and has no cure.

Marcus: I don't know but I heard it's transmitted through sex.

Philip: AIDS is a deadly disease.

Edith: It is a germ as well

Damiano: It's a virus which can be transmitted from man to woman and cause them to die.

These responses demonstrate that most Malawians, even those who are illiterate and live in rural areas, have some knowledge of HIV/AIDS most of which is at least based in fact. Some of my informants told me how they came about their knowledge of HIV/AIDS:

> *Margaret: Like in our village we have so many groups about drama, so these dramas come in our village and produced their drama and people go there to watch so most of them learn through those dramas and then they know what AIDS is all about.*
>
> *Dora: Some get the information from the hospitals, some from school like children and they are taught about HIV/AIDS.*
>
> *Samuel: There is Banja la Mtsogolo [a local family planning organization]. They have got a programme in which they go to the villages sensitising people about HIV, and after the campaign is over, people then forget what the people were teaching. And if there can be some implementations to this system, there must also be a continuous teaching of these words/ messages.*
>
> *Frank: From the radios, especially from two radios (which have) a mast.*
>
> *Bambo Nkhoma: Through radios, meetings, as well as from children who are at school.*

This superficial awareness of HIV/AIDS, however, is insufficient to combat many of the fears and superstitions that surround it. In fact, this shallow knowledge can actually contribute to increasing these fears and superstitions and promote a general reluctance to make use of testing services (VSO, 2002). It is well known that HIV/AIDS is a lethal disease for which there is no cure (though there remain some individuals who claim that this is not the case). This is a frightening fact and, when combined with uncertainty about means of transmission, signs, symptoms and vulnerability, provides some understanding of the 'AIDS scare syndrome' (Agadzi, 1990: 140) that has prompted confused reactions to the epidemic (see also Mann *et al.*, 1992; Bayer, 1996).

Despite a lack of comprehensive understanding of HIV/AIDS, however, there is an indication that the extensive AIDS awareness messages promoted by the Malawian government and international aid agencies have had some impact. The association between sex (particularly extra-marital) and HIV/AIDS is strong, as is the concept of HIV/AIDS as a fatal disease for which there is no cure (though this, as mentioned previously, may have its drawbacks). There is also a visceral understanding of the impact of HIV/AIDS on communities because many people have lost a significant number of family members within a relatively short period, often with similar symptoms. Two illustrations of this are provided below, in the form of kinship diagrams for two case studies, Daina Gulu and Mai Matthias.

FIGURE 8: KINSHIP DIAGRAM, DAINA GULU

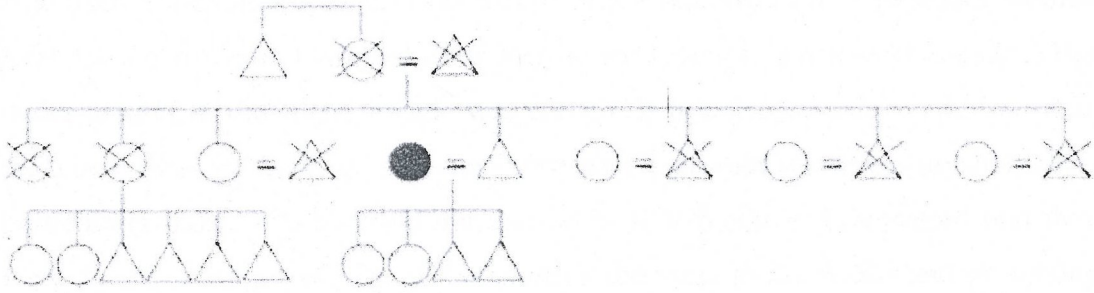


FIGURE 9: KINSHIP DIAGRAM, MAI MATHEWS

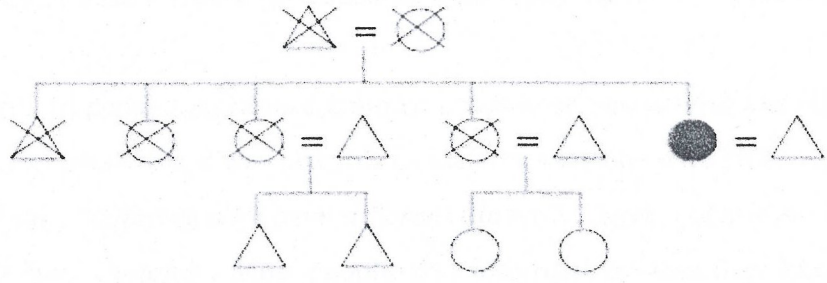
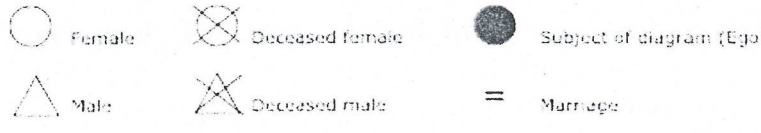


FIGURE 10: KEY TO KINSHIP DIAGRAM



Mai Gulu has lost all but one of her siblings, while Mai Mathews has lost every single one of her brothers and sisters. Neither knew if any of the deaths were AIDS-related. However, given that their siblings had all died while relatively young, there is a high probability that at least some of these deaths were AIDS-related. The decimation of a generation pictured in these two kinship diagrams is symptomatic of what is occurring nation-wide, even region-wide, and highlights the impact that HIV/AIDS is having on communities. As death becomes an ever more present reality of daily life, the coping mechanisms of individuals and communities are increasingly overwhelmed. The need for external assistance to such communities is pressing; this is further discussed in Chapter 7.

One person indicated that she was aware of the possibility of a pregnant woman infecting her baby, and also indicated that breastfeeding was not recommended. Her understanding of the latter, though, was that this is because the baby could '*increase the virus through sucking*'. In later interviews I prompted women on this issue, particularly those who had told me they were HIV positive. It appeared that they were aware of the possibility of transmitting the virus to the foetus and/or nursing child, but that they did not know what could be done about it. Women have few alternatives open to them, given that access to highly active antiretroviral therapy (HAART), as well as nevirapine and/or AZT (zidovudine), is impossible, as is the affordability of milk formulas as a substitute for breast milk.

The majority of people questioned claimed to know someone who was HIV positive, and many remarked that it was possible to identify someone with HIV/AIDS because they are '*thin*', '*suffering a lot from different illnesses*', have '*curly hair*' and '*sores*', and '*often have shingles*'. Most people also informed me that they knew a person who had died of AIDS. The evidence for this, though, is circumstantial since death certificates are not usually provided. Causes of death that were given to me included '*head pains*', '*high blood pressure*' (a common euphemism for AIDS), '*swollen ankles*' and '*pregnancy*'. That some of these were even listed as official causes of

death by the District Social Welfare Officer indicates the difficulty of assessing mortality figures.

Despite the general perception that it is possible to identify an individual with HIV/AIDS, there was wide agreement that none of the interviewees' personal acquaintances were HIV positive. Even some of the people I interviewed from the Limbikani AIDS Support Group, all of whom had been diagnosed as being HIV positive at the nearby St Luke's Hospital, agreed that, other than those in the actual Support Group, no one else in their communities was HIV positive. Thus, there is a level of denial of the HIV/AIDS epidemic that is problematic for people confronting the disease. For those who are diagnosed as HIV positive this can also increase their sense of isolation.

While the majority of people I interviewed informed me that people with HIV/AIDS are not treated differently from a social point of view, many of those whom I knew were HIV positive had not informed their relatives and communities for fear of forthcoming reactions. They provided me with some examples of how those with HIV/AIDS are treated when sick:

> *Mary: Most of the people are afraid to take care of those who are HIV positive because they think that they may take the virus through caring for the one who is positive and they can take the virus through her/his clothes or eating together with him.*
>
> *Bambo Nkhoma: They are treated differently in some communities because there are some who have a negative attitude towards the patient feeling that every time they touch this patient, means they will have HIV as well.*
>
> *Mbewu: Yeah, because somebody can not say 'I am positive' to people and I have only seen one gentleman who was Isack Jambu and was standing in the crowd and said that he was positive but some of the people in his life wouldn't like that and also the wife was not happy to see the husband doing that.*

Ignazio: They are treated differently because an HIV person needs a lot of things which cannot be found by village people, and as a result, people disregard the sick.

Grolia: Yes, if he take a glass of water and drink the remaining water in a glass must not be drunk by another one, because they think in the saliva there is also a virus.

Mark: In urban areas because of this awareness, they know saying, they have to use some gloves then they are touching the corpse so that they shouldn't have this fluid from the corpse.

Further evidence of the stigma associated with HIV/AIDS was provided during a home-based-care training session, conducted by Helen Jones from Emmanuel International. The following exchange took place, demonstrating that people still fear the stigma of HIV/AIDS.

Helen: have you had someone come to you saying they're scared they're HIV positive?

Every single person replies *'ei!!' (no)*

Woman 1: because they don't know, they're embarrassed

Chenoa: Why embarrassed?

Woman 1: Because they'll be pointed at and called 'an AIDS victim'

Sophie: (Do you tell people if you) have AIDS?

Woman 2: No: you say 'I have diarrhoea'.

Joe: You don't want to say.

Woman 1: the difference is that if you have AIDS people will say that she lies with men.

It is clear that despite an official discourse that denies that individuals who are HIV positive are treated differently, this is not always reflected in the reality of the lives of those who are infected with HIV. This can be explained largely by the fact that those who are not infected fear exposing themselves to those who are. What emerges from the above answers is the pervasiveness of fear of contamination felt by those in

close contact with an infected individual, as well as the misinformed nature of many people's knowledge of the condition. Furthermore, the fact that a person who is sick requires resources which are often out of reach of his/her caregivers is also acknowledged as a potential reason underlying the fear of a family member becoming HIV positive. A solution has been demonstrated by Paul Farmer in Haiti, where he works at a clinic that provides antiretroviral therapy to HIV-positive patients. He states that 'although AIDS remains a stigmatized disease...we believe that access to effective therapy has lessened AIDS-related stigma. The demand for HIV testing, and the opportunity for counselling, has risen since HAART was made available.' (2001: 405).

Treatment for HIV/AIDS

Drug regimens for the treatment of HIV/AIDS are largely unavailable within Malawi, despite a recent government promise to provide nevirapine to pregnant and nursing mothers (K. Munthali, 2001: 2). Harvard University's Centre for International Development reports that of the approximately 800 000 HIV-positive individuals in Malawi, thirty receive HAART (Abrams, 2001[9]). It is unsurprising, therefore, that people have turned to traditional healers and religious figures and/or organizations for help.

None of the people I interviewed knew of a traditional healer who could cure HIV/AIDS, though two people did admit to consulting a traditional healer about illnesses, which, because they were apparently AIDS-related, the local hospital could do nothing about. Outside of the interview context, however, it is clear that people will turn to traditional healers when government-provided health services fail to address the issue, as indicated below:

> *Fidelia: if my doctor cannot help me, I will go elsewhere.*
> Question: would you go to a traditional healer?
> *Fidelia: Yes, I will go to a traditional healer.*

[9] http://www.ksg.harvard.edu/ksgpress/bulletin/autumn2001/feature_aids.html

Mai Sani: If it is something that a doctor cannot treat.

Question: what can't a doctor treat?

Mai Sani: If it is emotional or caused by witchcraft.

This was reinforced in many of my everyday conversations. People would refer to visits to a local healer in their village who could help them with their complaint. The relative wealth of traditional healers and self-styled 'witchdoctors' also provides circumstantial evidence of their popularity, indicating the extent to which they are consulted. Finance also plays a part in the decision as to who is consulted. Though government hospitals are ostensibly free, transport there and back is not. Once at the health facility, a 20 *Kwacha* fee (approx. £0.20) is required for their health-record booklet. Frequently, too, they are (illegally) asked by staff to pay for prescribed drugs. Because of this, many people buy medicines from the witchdoctors established on the street opposite Zomba Central Hospital, who recommend various remedies ranging from dried snakes and monkeys to Panadol or Ibuprofen tablets. I was told by one of these witchdoctors that this was a good job for them because '*you gain more (financially) than (by) farming and it is good to help others.*' Consulting a traditional healer also serves to minimize time wastage, since queues at the hospital and health facilities are long and it can take upwards of a day to be seen by a professional for a minor complaint.

While Malawi does not have the prevalence of religious figures claiming to be capable of treating HIV/AIDS that is evident in other African countries such as Tanzania or Kenya (Hartwig, 1993; Kamaara, 1999) there is some evidence that they are about. The football field behind my house, for instance, hosted evangelical meetings on Sunday afternoons and, over a loudspeaker, I once heard the preacher ask for '*all of you, all of you sinners with AIDS, come to me now. Come to bathe in Jesus Christ and he will cure all your ills.*' When I asked informants if they had heard of any traditional healers who could cure AIDS, I was told by two that:

Margaret: I have never heard but I believe God can cure it.

Dora: No but only God

When I then asked if anyone had heard of a religious person who could cure AIDS I was told:

> *Margaret: Yes, some just pray and the infected person gets cured.*
> *Linly: Yes I know people like the Apostles and Zionists don't go to the hospital but they just pray to God until she gets cured. I saw one who was very sick but ended up walking after they prayed.*

There is evidence, therefore, that some Malawians believe in the possibility of a cure through divine means.

While there are no drugs available for treatment, home-based-care schemes proliferate in Malawi. These are run by international aid agencies such as UNICEF and the Malawi Red Cross, as well as by NGOs (e.g. Emmanuel International, CARE and Christian Aid). They teach people how to care for the terminally ill within their own homes in an attempt to alleviate the suffering of those with AIDS. While such programmes are necessary, it is unfortunate that their prevalence obscures the plight of AIDS victims to some extent, thereby lessening the urgency of the appeal for HAART to be provided to AIDS victims in Africa. According to Paul Farmer:

> The acknowledgment that there is the need for better prevention is important, and it is also time to turn our attention to the more than 30 million individuals already living with HIV. They need more than palliative care. The programmes extolled as 'community-based care' or 'home care' are inadequate whenever these terms are euphemisms to describe what amounts to hospice, and not very good hospice at that: no real analgesia, no antifungals, too few antibacterials, and no parenteral lines for rehydration. (2001: 404)

The only real solution to the HIV/AIDS epidemic is to provide HAART to those who are infected, an act which is necessary for humanistic reasons. By preventing the

further suffering and death of HIV infected individuals, as well as reducing the transmission rate[10], the survival of individuals and communities will be ensured.

Living with HIV/AIDS

Through the Limbikani AIDS Support Group I met several individuals who are HIV positive and discussed the impact of their status on their lifestyles. There is evidence of some denial that a positive diagnosis affects one's life significantly, with many respondents informing me that their reaction to their diagnosis was as follows:

> *Steven: I wasn't very disappointed but intended to know what to do in order to stay longer.*
> *Mary: I was very happy about it*[11].
> *Khalifi: I wasn't very sad but I was glad since they provided me advice of which can help me stay longer.*
> *Grolia: (shrug) I decided to join them (the Limbikani AIDS Support Group)*

One individual did admit that, initially, she had contemplated suicide (*'I was very disappointed and I decided to have some drugs to die'*) – a fact that is cited in literature as one of the reasons for not making HIV tests widely available (Bisika, 1995; Bisika, 1996; Munthali and Ali, 2000).

The majority of people had only told close relatives of their diagnosis, if they had told anyone at all. One sufferer, Mark, told me, '*I told my wife. I am afraid to tell other people.*' While he could not say specifically why he was afraid, he proceeded to inform me that people in his village do not know a lot about HIV/AIDS and, therefore, could be scared. Despite his diagnosis and membership of the Limbikani Group, he acknowledged that his understanding of HIV/AIDS was limited '*I only*

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[10] There is clear evidence to suggest that because HAART reduces a patient's viral load, the chances of infecting their partner are also reduced (e.g. Farmer, 2001; Nelson, 2002).

[11] This response does not indicate actually joy over the diagnosis, rather that the individual would rather not discuss their emotional reaction.

heard through a radio that it's a disease which is transmitted through sex. I just know that AIDS is a very dangerous disease which is having no cure and it is what is killing many people on Earth.'

Few members of the Limbikani AIDS Support Group had discussed with their families what would happen to their children after the member's death. Though several told me that the children would go to their mother (the children's grandmother), they also told me when prompted that this was because 'it is (done) this way' rather than because of any prior agreement. No one could tell me if there were any mechanisms (traditional or legal) whereby their children's inheritance rights would be secured, and most informed me that they had made no provisions regarding who would work their fields after their death – again, though, traditional customs ensure that this is decided by the male head of the family rather than individuals. As discussed previously in Chapter 3, it is automatic for kin to incorporate orphans into their households. Therefore, there is no perceived necessity for making such arrangements prior to an individual's death. Whether this practice will continue as more adults succumb to AIDS remains to be seen.

Issues related to the investigation of HIV/AIDS in Malawi

It is important to stress that discussions about HIV/AIDS are not commonplace within villages. That references to the disease increase during interviews, indicates that the emphasis placed on people's fears regarding the impact of HIV/AIDS on communities must be mitigated by the fact that these fears were generally only raised subsequent to being questioned on the subject. Furthermore, I was told frequently that people do not discuss this issue between themselves in the village; that I am a *mzungu* and had already evidenced interest in the topic is an important footnote to this discussion.

It was the investigation of HIV/AIDS more than any other topic that presented me with ethical dilemmas during the course of fieldwork. Many of the people with whom I discussed the subject asked for further information regarding the disease and its treatment and, while wanting to be honest, I did not feel comfortable informing

them of treatments such as HAART to which they would never have access. I did inform them, though, that there are many scientists who are working on finding appropriate medicine to treat AIDS.

I was also confronted with the issue of HIV-positive mothers who are breastfeeding their babies, and who will probably continue to do so for upwards of two years as is the common practice. The chances of them infecting their offspring are great. A woman who had been diagnosed as HIV positive at the birth of her child was still breastfeeding this child after nearly 18 months, and told me that she intended to do so until she became pregnant again. There are some women who have heard about the risks of breastfeeding while HIV-positive but who do not understand their alternatives. For those who are ignorant of the risk it seems cruel to inform them that they could potentially infect their child when they have no alternative means of feeding the child. For those women who, having heard of the risk, brought it up in discussions, I followed the information in *Where Women Have No Doctor* (Burns *et al.*, 1997). Several times (e.g. pp. 120, 285, 293) this book mentions the issue of HIV transmission through breastfeeding and points out that 'even if you are HIV infected, it is usually better to breastfeed than to use other milks or formula. In many communities the risk of diarrhoea and malnutrition from other milks is greater than the risk of HIV, especially in the baby's first 6 months of life.' (1997: 293). It further admonishes women 'do not blame yourself if your baby becomes infected with HIV. There is no way to know for sure how to protect your baby.' (ibid.). I took the decision, however, not to discuss the issue with women who had not raised it with me.

Buseh *et al.* pointed out that while researching HIV/AIDS the researcher is often called upon to provide information and resources for interviewees. They reported that:

> ...the focus group methodology acted as an intervention tool. The forum provided women an opportunity to discuss personal matters and to increase their knowledge through face-to-face discussions. There were several questions to the moderator during the meetings about HIV/AIDS, which were addressed at the end of the sessions.

> For example, women remarked that they benefited from the immediate responses to their questions and support for their concerns. This process of data collection allowed for reinforcement of positive attitudes and for increased understanding of sexual risk taking and its consequences. (2002: 183)

I experienced a similar situation within my research, and am hopeful that imparting my knowledge of HIV/AIDS went some way towards repaying the people who shared their lives with me during the course of my fieldwork.

No end in sight

Paul Farmer wrote in The Lancet:

> Many of those at greatest risk already know that HIV is a sexually transmitted pathogen and that condoms could prevent transmission. Their risk stems less from ignorance and more from the precarious situations in which hundreds of millions live; gender inequality adds a special burden, and is the main reason that, globally, HIV incidence is now higher among women than among men. (2001: 404).

It is clear, therefore, that HIV/AIDS programmes which stress prevention and condom provision will not have the required impact on the epidemic. This is particularly true given that access to HAART is so limited. Unfortunately, the lack of suitable treatment is due more to profit seeking on the part of pharmaceutical companies and no full-scale commitment by the international community to provide these drugs than to actual delivery constraints. In the same article, Farmer outlines how, and why, such drugs should be made available to AIDS sufferers:

> Tuberculosis offers examples of what needs to be done once the international community acknowledges that HIV is an international public-health emergency. Tuberculosis control, considered a public good, is by convention financed publicly. Patients do not pay for their own treatment, since those unable to pay remain sick and often infectious, perpetuating the epidemic; patients unable to pay regularly acquire resistance to first-line drugs and, subsequently, transmit drug-resistant strains of *Mycobacterium tuberculosis*. With tuberculosis, good treatment is prevention of both transmission and drug resistance.... Again, HIV offers important parallels. Although few would have predicted otherwise, we now have proof that high viral

> load is a strong predictor of HIV transmission. HAART drops viral load to undetectable levels in most patients, and should be considered central to the AIDS prevention arsenal.... Leaving aside all moral arguments, any economic logic that justifies as acceptable the orphaning of children is unlikely to be sound, since the cost to society, though difficult to tabulate, is far higher than the cost of prolonging parents' lives so that they can raise their own children. (2001: 408)

This response is echoed by many people working with HIV/AIDS around the world. For instance, Nelson states that '(antiretroviral) therapy is both a cost-efficient and compassionate strategy that will reduce disease transmission, lessen poverty, and diminish sickness and suffering.' (2002: 100).

HIV/AIDS is responsible for the loss of productive adults and an increase in the number of orphans, and is directly undermining the coping strategies and resilience of communities, threatening the very future of the country. Furthermore, it is probably the most significant contributor to the death rate in Malawi. The impact of this increased death rate is discussed further in the following chapter.

Conclusion: Exacerbating the effects of a mother's death

The key reason for including an analysis of HIV/AIDS in this thesis is that it is contributing to the increased rates of maternal death, and thus exacerbating the impact that such deaths have on kin and communities. The epidemic is contributing to a general impoverishment of communities and the overwhelming of traditional kinship structures. Coping mechanisms which, in the past, have ensured that orphans are automatically incorporated into the extended family are being threatened by growing numbers of orphaned children and incapacitated or dying adults. Having provided an indication of the scope of the HIV/AIDS epidemic in Malawi, the following chapter uses fieldwork data to illustrate how death is managed in the research communities. This data is presented against the backdrop of increasing mortality rates associated with HIV/AIDS, as discussed in this chapter.

CHAPTER 5: DEATH IN MALAWI

In conjunction with high HIV/AIDS rates, the ongoing food crisis in southern Africa contributed to there being a high death toll in research areas during the fieldwork period. In practice, this meant that nearly every visit to a field site would entail passing through an area where a funeral was being held. The frequency at which deaths were occurring and the cost of traditional funeral rites meant that many of the traditional mourning practices of the area were abridged, something which is discussed in greater depth in this chapter. It also meant that people had little time to process the impact of any one particular death; they were busy dealing with large numbers of dead and dying, as well as being confronted daily with their own mortality. Often, people would preface statements about the future with '*if I'm alive*', or '*if God leaves me here to stay*'. The fact that people were in the grip of an immediate crisis limited their ability to comment on the long-term implications of a mother's death. Too much was required of them in the here and now for them to worry about what more might be required of them in the future. Furthermore, few had had any opportunity to reflect on the impact of a particular death on their lives, at least not to the point where they were comfortable about articulating their thoughts. They were too engaged in tasks necessary for immediate survival.

This chapter begins with an analysis of the anthropological literature surrounding theories of death and then presents a description of death and funerary rituals in the Malawian context. As discussed in Chapter 2, the anthropological literature is incorporated with my research results in order to position my findings within a wider context. Since emotional expression at funerals is a key component of the ritual, some theories of emotions are also reviewed in this section. Their contribution to an analysis of funerals in Malawi is explained. One of the most striking elements of discussions of deaths, particularly deaths of mothers, is the emphasis on 'forgetting' the deceased. This is also elaborated upon, as is the gendered nature of death and the

specific elements of rituals related to a mother's death. Finally, the particular ramifications to a family and community of a mother's death are examined.

Anthropological theories of death

There are a wide variety of anthropological theories of death. Those which have some relevance to the context in which fieldwork was conducted are discussed in this section. These theories are used to illustrate the complex nature of mourning and coping with death that is undertaken by communities in the research area. Using the writing of theorists such as Durkheim, Hertz, Van Gennep and Clifford Geertz, various elements of social reactions to death in Malawi are elaborated upon and discussed within an anthropological framework. Several sections in this chapter use descriptions of rituals performed in the immediate aftermath of a mother's death and during the funeral to reveal underlying social structures and highlight the importance of kinship to the communities involved. The impact of a mother's death is felt immediately. An understanding of the resources expended for funerals is necessary to emphasize this impact on her kin and community.

Durkheim (1966 [1897]; 1995 [1912]) argued that religion and ritual are morally cohesive social forces that owe their origins to sociological, rather than individual psychological, factors. Religion and death rites serve to integrate an individual into society. While humans are physically separate, this separation is transcended through the use of language and symbols. Death expresses the tension between these two states, but also allows some resolution. A person's death is both the loss of the individual and the loss of a member of society, and both of these are addressed and resolved through death rites. In Malawi, there is a strong social emphasis on attending the funerals of adults in order to show your respect for both the person who has died, and for their family. Attendance at funerals serves not only as an emotional comfort to those who have suffered a loss, but also offers material support. Financial contributions are made to the family and, in the week following the funeral, many people will offer further support in the form of agricultural produce and small gifts to the children. That these rites are not followed for infants, echoes Durkheim's insistence that the importance of death rituals is to resolve the loss of a community

member. In many cultures, including those of the study areas, infants are not regarded as fully-fledged members of the community since they have not contributed to it in any way. Therefore, the death of an infant is not mourned in as elaborate a fashion.

While all human cultures attach some significance to the processes of human existence, such as birth and death, these processes are not understood and conceived of in a consistent manner. One of the main differences in understandings of death is that of its time frame: in Western societies death is generally conceived of as occurring in a single instant, hence the medical determination of 'time of death'. In many other societies, particularly those of Southeast Asia (Hertz, 1960 [1907]) and Madagascar (Bloch, 1971), death is a stage in a longer process that begins long before what we would cite as 'death', and which often continues for a period after the physical demise of the individual.

Hertz describes death beliefs from Borneo, where death is seen as a long process during which there is an 'intermediary period' during which the individual is neither alive nor dead. This period has a minimum duration (sufficient time for the bones to become dry and free of flesh), but can vary in length beyond this time. It is, however, always ended with a celebratory feast that marks the end of the process of dying. Among the communities studied for this thesis, there is also an indication of death as a 'process' rather than as an 'event'. There is evidence to suggest that the definition of death in Malawi is more flexible than the North American/European definition, as illustrated by a conversation I had with one informant, outlined below:

> My research assistant Philip had suggested that I interview a young woman who was living in his wife's village. This woman had recently lost her mother and was now looking after her four younger siblings (ranging in age from two to twelve-years old). During the introductory chat, she mentioned that her mother had died three months previously and this had made things very difficult for her because she now had to look after her siblings as well as doing all of the farming. The interview commenced and, when we got to the

questions regarding death and funeral rituals, I asked her if she and her siblings had to do anything special for and during her mother's funeral to indicate respect for a dead parent. She replied '*I do not yet know.*' Through prompting it emerged that her mother was very ill and expected to die very soon. When I asked why she had told me that her mother was dead, she replied that '*she is almost so, and is very sick. It is like being dead.*' Later, in discussing this with my research assistant, I was told that it is '*normal*' for people to count someone who is very sick as already dead '*if there is no way to cure them*' – a judgement which can apparently be made by any of the family/caregivers, a traditional healer or a medical doctor.

Though this characterization of death was only ever volunteered by one informant, when I raised it in conversations in different contexts people did not react with surprise that the woman had described the situation in this manner. This indicates that, despite this being a unique case among my respondents, it is not unique within the wider context. This case study has ramifications for the care of orphans: if someone can be seen as 'already dead' by society, due to their incapacitation, the strict definition of orphans as children who have 'one or more' dead parents indicates that there is a category of children who fail to have their needs acknowledged or addressed by development initiatives.

This concept of death as a process is used by Hertz to elaborate on other forms of transition that exist in society, and also to make general theoretical statements about symbolism and the need to restore the social fabric after the death of an individual. In Malawi, the reinforcement of the social order subsequent to the death of a mother is accomplished in a variety of ways. The supremacy of kinship ties as a means of organising social relations is evident throughout a funeral, as well as in the days and months that follow a woman's death. Kin reciprocity ensures that orphaned children are taken care of within their extended family group, thus ensuring continuity of the lineage. The primacy of kinship ties and the social emphasis placed on the necessity of becoming a parent in order to be regarded as a competent member of society are also evident in funerary rituals. Those deceased individuals who have not had

children have an X drawn in charcoal over their anus while the body is being prepared for burial. Other Xs may also be drawn over eyes and mouths, depending on the customs of those preparing the body.

Rules of inheritance become manifest as a result of a person's death. Often, they are reflective of more generalized social networks and customs such as kinship relations, gender roles, and concepts of wealth. For example, an issue of major concern to a great number of Malawians is that of 'property grabbing'. In this scenario, when a person dies (usually a male) their family descend upon the house of the remaining spouse and literally grab all of the possessions in the house and, sometimes, even parts of the physical structure of the house such as the roof, windows and bricks (Munthali and Ali, 2000). This problem is most obvious in matrilineal areas, where the kin of a deceased male are not entitled to any of the properties accumulated by the man during his life. Thus, the primary means of organising social ties, through an emphasis on matriliny and matrilocality, are insufficient to protect the rights of a widowed woman. Women are largely powerless to prevent this theft since they have few opportunities to represent themselves under traditional authority. Despite the national legal framework paying lip service to the rights of women, including the right of a widow to remain in possession of her belongings (Law Commission, 1996), there is a conflict here (as in many other areas) between traditional/customary law and the national law. This clash is based fundamentally in unequal gender relations that fail to provide women with guarantees that their rights will be respected.

Gender roles and stereotypes are also highlighted by what is inherited by whom. For instance, plates and cooking utensils are supposed to be the property of the female children, while the males have access to livestock, farming equipment and other items such as tape players, radios, and stills. This strict transferral of property according to the sex of the recipient is, however, not followed when property is 'grabbed' – regardless of the sex of the person doing the grabbing, everything that can be taken at that moment is appropriated. While this phenomenon is potentially an expression of the tension between matrilocality and the rights of the male's family, it

is more likely to be linked with the fact that families are living in escalating poverty. Material possessions are sought out of desperation and anything that is not of immediate use may be sold to increase a household's chances of survival.

Inheritance also highlights the notion of 'wealth' used within Malawian society. For those who acquire them, different items apparently have different significance, not necessarily related to their material value. While livestock may be of more financial worth than cooking utensils, for instance, their valuation far exceeds this monetary discrepancy. They are valued as much for the prestige they bestow on the owner as for the practical benefits associated with ownership. Similarly, houses are not supposed to be inherited following a person's death, a rule which does not make economic sense in a situation where the outlay to build a new house is beyond the reach of a large number of families. Traditionally, a single surviving spouse may remain in the house (though this is unusual if it is the mother who has died). If there are no surviving parents, however, or the father returns to his own village following the death of his wife, his children do not continue living in their former residence. I was told that this is because of the risk of witchcraft associated with the house, and with the increased likelihood of malevolent spirits being drawn to a house where a death has recently taken place.

Another anthropological theorist on death is van Gennep (1977 [1909]), whose central thesis is that death rituals are examples of a broader category of rituals that involve movement from one state to another, via a liminal period. This, of necessity, involves an initial separation (transitional/liminal) period, followed by incorporation into the new state, transformations that are also present in death, marriage, and initiation rituals. According to Huntington and Metcalf's analysis of this theory, 'ritual behaviour relates to the social function of recruiting and incorporating individuals that mature, age, and die into a fixed system of culturally defined roles and statues. This function is made necessary by the fact that society outlasts the individuals that comprise it.' (1979: 9). The role of funerary rituals in reinforcing social ties, as well as in restoring the health of a community following the death of

one of its members and promoting social cohesion, is discussed in further detail in the following section.

Death, and the rituals associated with it, reflects social values. They are important also in demonstrating wider values such as the nature of personhood and religious beliefs. Clifford Geertz propounds that death rituals are an important force in shaping social values (1973: 94-8). My ethnographic data are interpreted from a functionalist perspective. I show how death rituals reinforce social cohesion, but also how this cohesive aspect of rituals is being undermined by the pressure of increased mortality rates.

Funerals and gendered death

Death, and the accompanying rituals are gendered in a number of ways. These include gender-specific differential participation during the funeral ceremony, in mourning expression, in corpse preparation, and in the ramifications of a person's death.

Men and women have different responsibilities in funerary rituals, and they are segregated for most of the process. In this section, I provide descriptions of a female's funeral from the points of view of both sexes. It is important to note here that I only attended the funerals of women. Firstly, I present the text of an interview conducted with a male researcher at the Centre for Social Research. The funeral in question was that of the wife of another staff member. Based on the various funerals which I attended during the course of my research, I then describe the experiences of a woman at a funeral.

> Question: Can you describe what happened at the funeral, and who was there, in terms of where men and women were placed, how the children participated...?
>
> *Ned: Well, there were no children actually, well, there were young, very young children, on their mother's backs, but apart from that there were no children old enough to be walking around*

Question: Do you know where [the deceased's] children were?

Ned: No idea. (pause) Basically, it was in her mother's village, or in the children's mother's village....B and I drove down with the director and his wife. And then when we got out of the car there was a pretty much automatic separation – B went off with H's wife and I went with H. The first thing that happened was that we got a big plate of nsima loaded with meat and vegetables, and I'm not sure if that was because I was with [H] or whether that was standard. But I did ask them in Chichewa whether the women ... because the food was served up to us by women. I could see they were all around, and I asked if the women would eat too, and they said 'Yeah yeah'... I imagine that the big spread that was laid on in our place... We were there for about 40 minutes and then we just walked over to the inside of this tiny little church, not even really a church; it was about the size of this room and I didn't see into it... the women were at the back.

...The women were all seated around. It was like a hill. And I was sitting, looking at this little room; where they were singing; there were men and women singing, then, behind that, women were basically all sitting around, sitting in places around [the husband]... And we were sitting there for at least three hours. There was a collection...people putting in money... [the woman's parents]. There was a procession behind the coffin that went until dark and after that people were just walking around a bit for about 20 minutes. Oh no, before we left, which was actually after the singing, someone came round, and then there were three preachers speaking in Chichewa. I think the story told was Isaiah, and it was a Genesis story, Isaiah and something or other. I don't know, I can't remember... One of the preachers looked decisively HIV positive; there was no mention of AIDS at any point.

Another fella stood at the graveyard; he was lowered in... Before actually they came around with the white flag; I'm not sure if it was white, but it was definitely a flag, which indicated that the grave had been dug. That was the indication that we could go.

He led the procession and various people were asked to come up and put flowers actually on the coffin, on top of it: the dead woman's sister, [H] was asked; [the husband] was asked. Then there were some prayers before the coffin was lowered in; immediately the dirt was put on top of it. Everybody watched that being done. Then I came back.

Question: Was there any way, from the behaviour of the mourners, to differentiate the kin from the non-kin?

Ned: No, well the only exception was the woman's sister who was very, very, she was like wailing. I'd met her before. I knew it was her sister because when I went down to give my condolences to [the husband], she was there with [the body]... Apart from her, no. Her father seemed very shook. [The husband] seemed quite shook up. He looked more shook the previous day when I was at his house. I don't know, apart from her, no. The previous day I was at the house with the fire burning outside, and the women were sitting inside the house singing, and the men were sitting outside with [the husband] around the fire.

Question: Was that still counted as part of the funeral ritual, or was that...?

Ned: Yeah, it was, there was definitely a ritualistic aspect to it. But I don't know if the ritual was the same ritual or a different one. I just sat outside with [the husband] for a few minutes. I gave him some cash, actually. But I think when B went, she just went straight into the house. I'm not sure if she even came into contact with [the husband]. Y'know.

Question: OK. What did you talk about, when you were sitting around?

Ned: I just chatted with [H] about stuff completely unrelated. We talked about university. We didn't talk much at the start. Then it got to the stage when we'd been sitting there for so long, and [the husband] was sitting there with people chatting to him and people coming over to chat with him. But we certainly didn't talk about her or why she'd died. We may have mentioned it in the car on the way down. B and I were in the back and [H's] wife got in...then [H] said if he'd heard earlier we could have done something.

The funeral described above has many aspects that are common to other funerals in the area. These are discussed below, and compared with other funerals attended during the research period.

Care for the body

The sexes may be seen as differently implicated in the whole physical biology of death. Maurice Bloch contended that many cultures encumber women with the responsibility for biological creation and also individual death. Often it is women who are obliged to associate themselves with the worst of pollutions, intimate association with the corpse and its putrefaction. The phenomenon, however, is more general. Even in Victorian England a woman might be plunged into deepest mourning for one of her husband's relatives while he remained relatively unencumbered. As the Woman's World of 1889 pointed out, men 'mourn by proxy' (cited in Barley, 1995: 107). Discourse on pollution is not central to death in Malawi, though women are very clearly responsible for the care and preparation of a dead body, particularly if it is that of an infant, child, woman, or unmarried adult. The bodies of married men and village headmen or chiefs are usually cared for by their male peers. Even then, though, women are responsible for the cleaning of the body, and the men then take over the burial preparations and the vigil beside the body. Women's centrality to both birth and death is noteworthy, as the following fieldnote indicates:

> I took Elizabeth to the airport yesterday, and on the way over we were discussing how children are only buried by women. I asked her at what age children were buried by both parents. She wasn't sure if there was any set age, and went on to say '*death is very definitely a female affair, even if it's an adult's funeral it's the women who prepare the body. Men aren't allowed in with the body during a funeral, except when they come to pick it up to bury it. Yes, death is definitely for women.*' Ana's comment: '*Death and birth. What a combination!*'

In most circumstances it is understood to be appropriate for the bodies of adults (those who were married and/or had children) to be cared for by other adults, while any family member (usually a woman) may care for the body of a non-adult. A corpse is never left alone from the time of death to the actual burial. This is explained both as a sign of respect, as well as an attempt to ensure that no witchcraft is carried out upon the body, or that no body parts are stolen for witchcraft purposes. The practice is not, however, followed religiously under all circumstances, as the following entry in my field diary suggests.

> I arrived at KCH the day that one of the new twin babies (very high number of twins at both orphanages) died - AIDS-related. Queen Elizabeth [Central Hospital] is on strike, so the nannies had to prepare the body themselves, and asked if I wanted to help. I went in with them, and they undressed the baby. I had to leave almost immediately thereafter, though, as they were squeezing the head and belly to get rid of mucus, blood and other fluids, and I felt like vomiting. D also left at this point, and we were called back in when they'd finished. They crossed the baby's arms over his body and then wrapped him up in an old *chitenje*. They were then going to leave him in the garden shed until the hospital re-opened on Monday and they could give the body to the hospital, but [D insisted] that that was undignified. She cleared out a room for him and left him there...the nannies were obviously bemused, but went along with it.
>
> I asked them what happens to babies after they die and they gave me the '*they become angels*' response. When I pressed them about 'traditional' beliefs in their villages they stuck to that, Christianity being more 'traditional' here than it is in Europe at this point!

Despite the lack of a vigil over the body of the baby described above, caring for a baby's body until it is buried is still generally seen as the ideal practice. In the above instance, the decision to leave the body alone was influenced by the fact that the burial could not take place immediately and because the nannies had many other

tasks to carry out. The lack of kinship ties between the nannies and the deceased could also be a factor, as could the fact that the body was within a relatively secure compound. Babies' bodies are sought after by witches for their sorcery (as I was informed by the hospital employee who found an abandoned baby at Queen Elizabeth Central Hospital) and, therefore, they are generally protected by their kin in order to prevent such desecration.

A new baby was abandoned in the compost heap outside the hospital at QECH – it was found by a hospital employee who is apparently very upset because '*it's a sign of witchcraft. It could be that a person needed the baby for a spell, but then was interrupted so couldn't finish taking the parts she needed.*'

Question: So you think the witch was a woman?

Nurse: No, it could also have been a man. Baby parts make people very powerful.

Question: How?

Nurse: I don't know. I am not a witch.

Question: why babies in particular

Nurse: I don't know why, I just know most people use that. Especially the cord.

Question: Why?

Nurse: (shrug) I am not a witch.

The umbilical cord is understood to be a source of power, and is particularly dangerous to men and/or the baby when viewed by a man. This is also cited as a reason for men not being involved with the burial of infants.

Lovemore's daughter died when she was 2 weeks old and was buried by her grandmother (Lovemore's mother) in the same cemetery (centre of Zomba, multi-denominational) as the baby's mother (who'd died in childbirth): '*this is really her mother's job, but of course under these circumstances...*' Interestingly enough, Mai

Monica then tells me that because the baby was *'just that young'* Lovemore would never have even held it.

Question: Why not?

Mai Monica: Men can only hold a baby that is older than 2 weeks.

Question: And if they hold it before 2 weeks?

Mai Monica: Nothing happens, but that is culture, according to tradition.

I asked why men didn't bury babies and was told: *'until the age of 2 months only women will bury a baby. This is because the cord is still with the baby, and the men must not see it.'*

Question: Why not?

Mai Monica: Because it is a secret.

Question: Why is it a secret?

Mai Monica: Ah, it is a secret, something for women to know.

Question: Will anything happen if a man sees it?

Mai Monica: It is possible that they may die.

Question: Who may die?

Mai Monica: Any of them, either the man or the baby. But probably, most likely, the baby.

The majority of interview respondents stated that there is little difference in the care provided to the bodies of adults and non-adults or males and females. Different practices are manifest at the funeral rather than in the preparations for burial. Some of the answers received to the question of differential care included the following:

Margaret: No difference whether a girl or a boy.

Ignazio: When a boy dies limited people attend the funeral while a parent is dead many people attend because parents are very known.

Feria: There is no difference, both are treated likewise.

Dora: Many people attend the funeral unlike when the dead one is a child, where limited numbers of a people come to attend the funeral.

Philip: There's a difference if the dead is a young person because a young person's dead body is cared by everybody, but if the dead is a parent, it means parents are the ones who care the dead body.

It is clear that it is the social identity of the deceased individual that influences funeral attendance rather than their gender. Thus, the funerals of infants, too young to be assimilated fully into the community, are only attended by a mother and some of her female kin. The funerals of older children may be attended by their fathers, as well as by an increased number of relatives. It is only the funerals of adults (fully integrated members of the community) however, which are attended by wider social groupings as well as kin. The funeral serves as an opportunity to mourn the loss of a productive individual, and reinforces social and kin networks that are necessary for the survival of the community.

Funeral timing

Funerals generally take place within a day or two of a person's death. The only reason for extending this period somewhat (and never for more than a week) is to wait for relatives to travel from a distance. The majority of the funerals I attended, however, took place the day following the death, since the woman's relatives were within the same village. The immediate kin, therefore, were in the house preparing the body for burial. Other attendants arrived as soon as possible after getting word of the death. Since I was living some distance from my research sites, I would generally arrive after the midday meal – both because of the travelling time required and because I did not feel comfortable being fed at a funeral during times of severe food crisis.

People may make multiple visits to the house of the bereaved depending on the interval between hearing of the death and the actual funeral. In the village funerals I attended, the first visit often coincided with the actual funeral, as there was no need to wait for the arrival of relatives and the ceremony was arranged immediately. If the funeral was postponed for whatever reason, however, the first visit would serve as an opportunity to express one's condolences, perhaps donate some money towards the

expenses of the funeral if one could afford to, as well as to be informed of the time that the funeral would take place. While it is considered a show of respect for people to visit at the house immediately upon hearing about a death, this does not seem to be uniformly practiced. My research assistant, Philip, told me that now only those who were close to the deceased will visit immediately. It is then their obligation to inform the rest of the community of the funeral arrangements. Therefore, most people make only the one visit at the time of the funeral. If people made multiple visits to every house where someone had recently died '*no farming would happen*'. There is a practical reason, therefore, for relying on key people to spread the details of the funeral arrangements, and this is inextricably linked to the increased number of funerals associated with AIDS-related deaths. The overwhelming number of funerals taking place on a weekly basis within any single community precludes people from participating in the normal rituals to the full extent. They are still required to farm their lands, provide for their families and care for their own sick.

Placement of mourners

The physical separation of men and women is standard throughout a funeral[12]. Women usually congregate close to the body, if not actually surrounding it, along with the female kin of the deceased. This usually entails women being inside the house, while men squat around the outside. The women may be joined by some men from a local church group, who attend the funeral as members of the choir, but these will be the only men within the inner sanctum. No footwear is allowed in the house. On my arrival I would normally use the opportunity of removing my shoes to add money to the collection plate that is kept near the footwear for this purpose. Money is collected at various points during the funeral and it is used to offset the costs of the funeral and the travel expenses of close relatives. Women are required to wear a *chitenje* to all funerals. Periodically they raise these to cover the heads of those who are wailing their grief.

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[12] This physical separation of men and women is echoed in other spheres, such as church attendance and many social gatherings.

Women are responsible for the wailing at funerals, and it is the only public expression of grief. The women's area, therefore, is generally very noisy, due to both the wailing and the singing. The choir sings throughout the funeral as a sign of respect for the deceased and her family. All the while, however, most attendees sit around chatting, catching up on mundane news. At any time, though, even in mid-sentence a woman might commence wailing. Emotional expression during funerals is discussed in more detail in the following section.

The only children present are those who attend with their mothers because they are very young and still nursing. Adolescents may attend only if they are members of the immediate family. The role of mourner is left to those women who are adults. All of the women whom I recognized at various funerals were mothers in their own right, something which used to be a requirement for attending a funeral. Mai Edwin informed me '*it is tradition that only mothers go to a funeral [when prompted, she added that fathers could also attend]. They have suffered with birth, and (understand what) death is.*' When I asked if this were still the case she replied '*today anyone can go (to a funeral).*' She had no explanation for why the custom had changed, but a general relaxation of traditional norms is observable in other aspects of daily life, and could be partly responsible for this trend. There could also be a link with the increased number of funerals taking place as a result of HIV/AIDS.

People often cite funeral attendance as having a negative impact on their abilities to pursue their livelihoods, as well as placing an increased financial strain on their budgets due to the necessity of having to contribute financially. It is customary for all adults to attend a funeral in their village, and to attend the funeral of a member of their church, regardless of how little they were acquainted with the deceased. The number of mourners present at a funeral reflects directly on the regard with which the deceased was held by her community, and her social standing. Mourners are faced with the expense of attending a funeral, as well as the opportunity cost in terms of loss of productivity.

Emotions and death

The death of a mother has a profound emotional impact on orphans and remaining kin, yet this aspect of the experience is often overlooked in the literature that focuses on increasing mortality rates in Africa. In an attempt to highlight the severity of the HIV/AIDS epidemic, much of the literature produced by organizations such as UNAIDS and the World Bank focuses on dry statistics rather than attempts to portray the personal tragedy experienced by those who lose a mother. Regardless of the cause of death, the loss of a mother has an impact beyond that of the loss of a caregiver or financial provider. It has yet unknown ramifications for the mental health of a generation of orphans. This section presents a discussion of emotional expression at funerals, and is followed by an analysis of the emotional impact of death on surviving kin.

Expressions of emotion at funerals are often misunderstood cross-culturally. Since anthropological accounts of grief management did not focus on North American and/or European funerals until relatively recently, analyses of the ritualized aspect of grief at funerals in a variety of cultural contexts has often led to claims that the 'other' is less affected by death than is the 'self'. Outlined below is some general information about the anthropological study of emotions, particularly as they relate to death. This is followed by a discussion of the particular emotional expressions evident in the Malawian funerals attended during the course of this research.

The study of emotions has progressed from the assumption that they are purely biological to include analyses of how their expression varies culturally and, crucially, how their meanings are determined through a process of negotiation (Lutz and White, 1986: 408). Since from an early age people are generally taught what emotions may be expressed, in which contexts this may happen, and which means of expression are appropriate, the translation of emotional responses between cultures can be difficult. While it is generally agreed that feelings of happiness, surprise, fear, anger, disgust and sadness are universal (ibid.: 410), the degree to which they may be experienced differs between cultures, as are the contexts in which they are expressed. The social construction of emotions does not easily allow outsiders to understand

how insiders are experiencing an emotion, and this often leads to misinterpretations. The argument that other cultures feel certain emotions, such as grief, less strongly than do Western cultures may also be used as a means of differentiating self from other. By emphasizing the lack of emotion that other parents demonstrate over the death of a newborn child (e.g. Scheper-Hughes, 1992), their (lack of) humanity can be inferred.

Rosaldo (1989) has highlighted the difficulties of emotional translation by using Bourdieu's concept of the 'positioned subject'. This subject is understood to occupy a specific place in society that allows a particular view of events. It is difficult, therefore, for ethnographers to gain a full understanding of their subjects' emotions since they have not shared similar backgrounds and experiences. This problem of cultural translation of emotions, however, is not the only difficulty encountered when investigating the subject within a cross-cultural context. Terminology also presents a difficulty to the researcher. In Chichewa, for instance, there is no equivalent term for 'emotion' or 'feeling'. One must inquire instead if a person is happy, sad or worried. This then presents concerns of leading the discussion. Participant observation enables the researcher to gain a better understanding of emotions expressed by research subjects. It is an important tool, therefore, in understanding emotions cross-culturally.

The expression of emotions at funerals

Godfrey and Monica Wilson (1945, in line with Radcliffe-Brown, 1964 [1933]) theorize that expressions of emotion during funeral rituals are never normal, but fall within an obligatory pattern. Social relationships of the Nyakyusa (Tanzania) are defined by membership of family, village and chiefdom, and this membership is confirmed and demonstrated through attendance at funerals and the exchange of cattle. Attendance at funerals is obligatory, lest accusations of witchcraft and complicity in the person's death be levelled at those who fail to attend. This ensures that people gather to reaffirm their social ties to their kin. The situation in Malawi is similar in that attendance at funerals is also seen as a necessary part of community membership. This obligation to attend is being undermined, however, by the growing

number of funerals occurring in an age of HIV/AIDS and increasingly common famines. Thus, the status of the deceased is often taken into account by potential funeral attendees, who may decide not to attend if the deceased is not deemed to be of high enough status. Since funeral attendance does not only imply the opportunity cost associated with lost work-time, but also a financial contribution to the family of the deceased, people's resources are strained when they are required to attend a large number of funerals.

In Malawi, the manner in which emotions are expressed during different funerals are similar, but variations do exist. As would be expected, some men show their emotions more openly than do others. Of the various funerals I attended, I witnessed men who acted as though nothing had changed in their lives, and others who were clearly devastated by their loss. There are no standard behaviours expected of men, however, instead it is women who follow particular mourning guidelines. The female kin of the deceased don *chitenje* and, during the funeral these are frequently brought up to cover the face to indicate sorrow. Women also use wailing to indicate their grief. It is understood to serve as a catharsis for the community as a whole, not only the person doing the wailing. The ritualized aspects of mourning – covering one's head, wailing, and singing – are predominantly carried out by women (men may be members of the choir, but these are usually non-kin), thus furthering the association of death as 'women's work'.

It is commonly understood that the most prevalent way of expressing one's sense of loss is through participation at the funeral ceremony. I was told that the following are examples of how people demonstrate their grief at losing a member of the community:

> *Philip: Relatives complain that they have lost the counterpart.*
> *Edison: All are very disappointed and they help in other activities.*
> *Ignazio: They show their concern by coming to the funeral, crying and even putting the body in the grave.*
> *Damiano: They attend the ceremony though no help is given.*

Margaret: Some are affected but many are not. It depends on the (dead) person's behaviour.

Catherine: Relatives show concern with funeral by feeling sorry for losing their relative and suffer a lot.

Tereza: They provide coffins and clothes to cover the corpse.

Daina: People are more concerned if it's the young person who has died unlike if it is an old person, if he/she was old, they say she has to rest.

Participation in funeral rituals is a common means of reinforcing social ties that are threatened by the deaths of individuals within a community. Cultural forms and institutions may be analyzed as means of 'insulating the experiencing subject from the vicissitudes of emotion' (Lutz and White, 1986: 412). Rituals, therefore, such as those exercised in association with death, can be described in functional terms as coping mechanisms for enabling the bereaved to come to terms with their loss. Englund points out that rituals are transformative events that allow individuals to progress through various life-cycle stages, and that these transformations occur through the body rather than through discourse. Since African constructions of personhood 'often represent the moral person as a being entangled in relationships' (1998: 1166) and 'sociality [as] a prerequisite for the experiencing self' (ibid.), participation in transformative rituals is essential, particularly in the case of funerals because funerals serve to reinforce kin ties. Overland, too, in the context of Cambodian refugees, points out how funeral rites bring relief to the living by providing continuity to the familial relationships – extending 'love, compassion and comfort to the departed' (1999: 3).

Who is most affected by deaths?

While most deaths elicit sorrow in their respective societies, the extent to which this may be expressed or held back varies between cultures, and is a further example of the way in which death is constructed differently around the world. Emotional displays may be strictly regimented, or even unnecessary (such as with the death of children in Brazilian slums – Scheper-Hughes, 1992), and different societies may mark out mourners by their personal appearance. As mentioned previously, it is

customary in Malawi for the death of infants to be attended only by the mother and some of her female kin. It is an essentially private gathering and there are no public expressions of mourning. Mothers, however, are understood to be sad following the death of their child. The remedy for this, as for other deaths, is for the woman to 'forget' her dead child, and continue living her life as though the child had never existed. Having another child to cement this process of 'forgetting' is recommended. The analytical category of 'forgetting' is discussed further in the following section.

With regard to the deaths of adults, however, there is an idea prevalent among Malawians that *'women are much affected unlike men'*. The reasons for this differential experience were described to me variously as follows:

Samuel: Women are much affected at the funeral because they see the dead body.

Philip: Women appear more concerned, because they know problems of delivery.

Catherine: Women are affected most at the funeral because they are the ones who look after children and they remember the delivery pains.

Margaret: Women since women are weak unlike men.

Mai Sani: Women due to labour pains

Gladys: Women are much concerned mainly in cases of losing their husband since they were two in one body.

Patricia: Women because they are the ones who give birth and know well how it pains. They affected with the death but parents are the ones who are much affected.

Damiano: Wives are very much affected since she knows that she has lost a partner.

Dora: Women are concerned most at funerals because they are the ones who give birth and know the pains they had.

Clearly, a woman's role in childbirth and as primary caregiver for children is seen as reason for her grief at funerals. Men, who are usually less involved in household

care, are seen as being distanced from the emotional attachments that are reinforced through daily acts of giving care. These reaffirmations of kinship ties through daily activities don't mean, however, that women are the only ones who are affected by death. There is also a differentiation between how kin and non-kin are affected by a death, which echoes the Western ideas of grief, namely that the family feel the loss more acutely than do others, as demonstrated by some quotes from interviews:

> *Grace: Relatives are much affected because it's their relative who died.*
> *Ellen: Relatives are much concerned.*
> *Malita: The relatives and children [are most affected].*
> *Lily: The relative of the one who have died [is most affected].*

Thus, the concept of who is most affected by death reinforces notions of kinship, i.e. kinship is not only biological, it is also created and re-created through acts of care, reciprocal exchanges and aid, as well as residence patterns. That relatives are most affected by a death is understood. That within this category of relatives, it is women who are most affected by death corresponds with this definition of kinship, because it is women who reinforce and generate these ties of kinship.

'Forgetting' a mother's death

As mentioned previously, emotions are socially shaped, but they are also socially *shaping* especially insofar as socialization makes a child's chances of experiencing certain emotions more likely (Lutz and White, 1986: 425). Levy (cited in Lutz and White, 1986: 418) uses the terms 'hypocognized' and 'hypercognized' to explain the way in which different cultures either mute or elaborate certain emotions respectively. Lutz and White also point out how 'the most commonly occurring emotions in a society can be seen as markers of the points of tension' within a particular society (ibid. 421). Scheper-Hughes in her book *Death Without Weeping* (1992) illustrated how emotions (and not solely their expression) can differ according to social class. Rosaldo (1989) maintains that hierarchical societies focus more attention than others on regulating the inner

emotional self, and the interpretation of key emotions (in this case – among the Ilongot - anger) is indistinguishable from the task of ethnography.

Within the context of this research, one of the key responses to death, and particularly the death of a mother, is that of 'forgetting' the deceased. It is understood that a person who fails to forget a loved one who has died will suffer physically as a result. Children who are orphaned are particularly vulnerable due to their close ties with their mother, and may even die should they fail to forget her. The emphasis on 'forgetting' may be encouraged even before the death of a mother if she is very ill and her death is understood to be a certainty. Edith, for example, explained to me why she would not be telling her grandchildren about their mother's death:

> Question: did you tell the children that their mother is going to die?
> *Edith: No I was afraid that they are going to be crying.*
> Question: The children cry even at the funeral ceremony so how does it differ?
> *Edith: telling them before hand can make them very much disappointed and can commit suicide. They must forget.*
> Question: what do you do to make the children forget their mothers?
> *Edith: never try to remind them.*
> Question: do you think it is important for the children to forget their mother?
> *Edith: yes.*

In all instances, 'forgetting' is emphasized immediately upon the death of the individual. This is even evident within the funeral ritual itself. Older female children who participate in the ceremony are expected to wail when they feel inspired to do so, but only for brief periods of time. They are also supposed to 'forget' their grief sufficiently to help with the task of feeding the visiting mourners. A lack of reference to the reason for the gathering, or to the deceased, was noted at most funerals I attended. This is true among the women as well, where commonplace chatting is interrupted often by the wails of the mourning women, but little attention is paid to this ritual crying.

Signs that orphans are grieving for their mother include interrupted sleep patterns, a lack of appetite, crying and fighting with other children. Caregivers who notice these signs will generally take action to promote the process of 'forgetting'. Thus they may do any of the following:

Dora: I will show love to her so she does not miss (her) mother.

Gladys: Telling the child to forget is important. If (they don't forget) they will be sick.

Damiano: Perhaps a church person could be called for advice.

Patricia: I will warn her of the danger of remembering.

Edith: Orphans miss their mother if they are not fed or are ill-treated. So it is important to take care of them properly.

This emphasis on forgetting the deceased mother serves to integrate the orphan(s) into their new household. The success of this endeavour also serves as an indicator of the quality of care being provided to the child. As Carsten suggests, it can also function as a means of emphasizing alternate kinship bonds, such as those between siblings:

> The idea that forgetting who your relatives are represents a loss, and is part of a negative process, a flattening of personhood, a diminution of kinship, a reduced temporality, has been far more prevalent in the literature than more positive accounts. Here I suggest that this kind of forgetting is not only an active process, but that it is linked to other aspects of identity...most notably an emphasis on siblingship. (1997: 271-2)

Malawians are generally encouraged to actively forget wrongdoings that others or society have committed against them. They are not supposed to dwell on things that they cannot change in their lives and surroundings. These injunctions promote a forgetting of negative instances and emotions, the ultimate of which is experienced as a result of the death of a mother. Thus the order to 'forget' one's mother is consistent with a general cultural pattern of promoting social cohesion by discouraging people from dwelling on emotions that are both harmful to themselves as individuals, and to the community as a whole.

The death of mothers

While fieldwork for this thesis concentrated on the impact of maternal death, and thus didn't look specifically at the impact of a father's death on either the family or the community, interview respondents differentiated between the two to some degree. It is clear that a mother's death results specifically in the loss of a primary caregiver for her children and the necessity of seeking a new caregiver (usually a female relative of the deceased), whether or not the father is still alive. While the death of a father often has financial ramifications for children, the death of a mother has wider implications for her children, and thus her community, and the financial ramifications of a mother's death affect her extended kin.

'If a woman dies, it means that family is already destroyed' (Buseh *et al.*, 2001: 177). When I repeated this sentiment to some informants, they nodded and agreed with it, saying that '*this is true also in Malawi*' and '*everywhere it is the same. Women are our family.*' The truth of this statement was highlighted throughout the period of research. It is, for example, the specific death of a mother which is the factor that makes an orphan eligible for assistance at infant homes in Blantyre. Hospital personnel pointed out that if a mother dies in childbirth at the hospital, there is '*no reason*' to send the child home with the father, since s/he will generally die from lack of care and nutrition. Due to the historical realities of migrant labour in Malawi, women are often the sole parent even when married. Given that children belong to the mother's lineage in the matrilineal societies studied, the loss of a mother results in one of her female kin taking over the responsibility for the care of the orphans. This may not necessarily take place immediately. In some cases fathers attempt to stay in their wife's village to actively participate in looking after their children. Sooner or later, though, they generally leave for work or for re-marriage and the children's care reverts to their maternal kin.

The interviews showed some evidence that the aftermath of the death of a mother or father, are considered equally devastating. Many interviewees, however, elaborated

further by saying that the impact of a mother's death is greater on a family because of her role as primary caregiver.

Ignazio: When a woman is dead, more people are concerned, including the children of the dead, because the mother plays a greater role in childcare.

Damiano: People are much affected on a woman's funeral since she plays a very big role in making a family. So people are affected that the children left can be in trouble.

Delex: People are much affected it is a woman because mostly she leaves children who lacks care so due to that not all caregivers are good some children can be ill-treated unlike a father.

Philip: Women's death brings more concern, because women take a greater part in the childcare part.

The interviewees also reiterated that women tend to be more emotionally affected by death than are men, therefore they may suffer emotionally as well as financially, following the death of their spouse. Men, it was maintained, don't suffer as much and, therefore, can forget their dead wife sooner, a sentiment that is confirmed by swift remarriages.

Daina: Women are much affected if her husband die, but if it is a woman die her husband can go and marry another wife.

Ellen: No difference but the woman's concern last longer than a man's.

Despite traditional advice being for a man to wait for a year before remarrying, this is seldom heeded. One widower of my acquaintance met and became engaged to a woman a month after his wife died. They were married four months later, which provoked a shocked reaction from their friends and acquaintances as being in very poor taste. This scenario was repeated with three other widowers known to me, though with the period before remarriage being between six and eight months. In the villages you often hear of men remarrying within half a year of their wife's death. This is viewed either as being a practical solution ('*men have difficulties living alone.*

They must live with someone to care for them.'), or with shock for the violations of traditional norms this represents. A few people acknowledge that this is also a cause for concern with respect to HIV/AIDS, since the men may then infect another woman.

The role of caregiver is seen as the major part of the loss upon a mother's death. This has ramifications not only for her immediate household, but for her kin and community as well. It is acknowledged that if she dies leaving a child old enough to act as caregiver for her/his siblings, the impact of her death upon her kin is minimized. Caregivers would also often inform me that, no matter the level of care received by orphans from their new caregivers, they would have been better off with their own mothers, since nothing is the same as a mother's love. Below are some of the implications, specific to a mother's death, that were of concern to my informants.

Household tasks become more burdensome:

> *Feria: Lack of assistance. As you know most family chores are done by women. This affected me also when my daughter died [leaving four children].*
>
> *Ignazio: When a woman or a girl died, problems arising are cooking and washing.*

Orphans lack emotional 'tender' care and, perhaps, physical attention:

> *Margaret: Children left lacks tender care, which a caregiver cannot manage.*
>
> *Philip: The problem is that we lose the care that they used to give us.*
>
> *Samuel: When a mother has died, children are not well cared as the mother herself used to.*
>
> *Mai Sani: If the dead mother has left children then the children starve and they can have no one to care for them.*

Damiano: More problems if it's a woman who has died because she might have been for sending out children to school, finding clothes and food for the children.

Lonnie: If we lost a mother, then we lose a future. This comes because the mother is the one who produces babies and if a mother dies the father himself can't produce children in that family. If we can lose a father, the mother can find another husband for them to have children.

Kennedy: The way I've seen in the communities, when a mother dies, the rest of the family have problems because the children who are left behind are not well cared by the husband when he is alive and sometimes you can see that somebody who is there the grandmother who is looking after the children is old and maybe her husband dies sometime back and is an elderly widow. So there are a lot of problems which interferes when the husband dies, the children are left behind with their mother whereby they can suffer because she doesn't have a source of income but still, they're being cared, for example: There was a time whereby a wife died, and the husband collected all the children to go with him and this gentleman married another woman, what was happening was, when the husband leave for work or in his absence that second wife was ill-treating the children because they were not hers. So there are a lot of problems when a mother dies than the husband.

The mental health of orphans:

Damiano: When a woman died and left the children, the children are much affected with more problems because they always think about their mom.

Malita: The children in the family feel sorry if a mother dies because usually in African culture we are used that the families/children in the family are well looked after/nursed by the mother but the father just goes out to find some bread but who prepares that bread is the mother. So the families are much affected if the mother dies because she shares the day to day problems with the kids. If a child comes with a problem, she talks to her

mother that she has a problem and the mom is the right person to assist the children because husbands most of the times are outside the house doing some pieces of work in the fields or in the government services or in companies to find money to the family and people who are around the house are children and the mother discussing their problems.

Grace: Children are greatly affected at their mother's funeral and they don't react in any other way. They stay quiet and are taken to their friends to chat so that they forget. This reaction differs if their father is dead, children know that our mother is going to care for us as our father is dead, because woman play a greater part of caring children.

Conclusion: Death and gender

As my findings demonstrate, the death of a mother is understood to be disastrous for her kin, and particularly for her orphaned children. Furthermore, the specific ramifications of a maternal death impact greatly on the surviving female kin, who predominantly bear the burden of orphan-care and the associated household impoverishment. Female children, too, are severely disadvantaged, since not only are they are often taken out of school to assist in the management of the newly created household, but they also lose the care and emotional support of the aunt who becomes their caregiver, with an associated re-negotiation of this relationship. It is clear, therefore, that gender influences not only the roles and responsibilities of an individual within the context of funerary rituals, but also the degree to which an individual bears the consequences of a mother's death.

As can be seen from the preceding analysis of my fieldwork results, concerns subsequent to a mother's death range from the relatively mundane to anxiety for the psychological and emotional wellbeing of orphans. These apprehensions are specific to a mother's death and, as highlighted by most case-studies, are understood to be more damaging to a child than the financial repercussions of losing a father. Crucially, it is a mother's love and caregiving that are lost, leaving most orphans in need of alternate care arrangements. These arrangements are discussed in further detail in the next chapter.

CHAPTER 6: TYPES OF ORPHAN CARE

The preceding analysis of death and its associated rituals has illustrated how a mother's death is managed within the kinship context previously described in Chapter 3. The increasing mortality rates associated with HIV/AIDS have resulted in funerary rituals having a greater impact on kin and community because of their very frequency. Households do not have time to recover between deaths, thus the impact of a single maternal death is compounded by the death of another within the same family – a scenario that is ever more common. The combination of these factors is resulting in the destruction of traditional coping mechanisms, and it is becoming increasingly common for children to be cared for outside of the extended family. While this is still not true for the majority of Malawians, it is inevitable that, without support, the remaining kinship structure will be overwhelmed beyond recovery and a greater number of children will require institutional care.

This chapter examines the most visible impact of a mother's death on her family, namely the need to provide alternate arrangements for the care of her children. It describes the kinds of care that are allegedly available to Malawian children who have lost their mother, and who, therefore, are classified as orphans. Sources of support for families looking after OVCs are identified as such primarily by government social workers and those who are employed by such agencies. In reality, however, this does not necessarily translate into identifiable resources, or resources that are accessible by rural Malawians themselves.

Three categories of care have been identified, namely: orphanage-type institutions, children's villages, and community networks. Though these represent three distinct means of caring for orphaned children, in many instances these categories are not mutually exclusive, and help may be sought from a combination. My research focused primarily on the last category of orphan care, mainly because this is the coping strategy most commonly employed by those with orphaned children, since it is the most readily accessible and the closest fit to cultural norms. Evaluations of

other care mechanisms were carried out, however. Interviews were conducted with some members of staff working in orphanages and children's villages, and some participant observation was carried out at several institutions.

With the current orphan 'crisis' in southern Africa in general, the number of organizations with the remit of caring for orphans (particularly the vague category of 'AIDS' orphans) and vulnerable children is increasing dramatically. Most international donors seek to provide at least some of their funding to initiatives that aim to help orphans, and the plethora of organizations doing so means that a comprehensive evaluation is impossible to perform. Therefore, the following discussion utilizes specific examples of care-providing institutions to illustrate *types*, but should not be considered as exhaustive.

While the official Malawian government's stance on orphan care states that there is a wide variety of types of assistance available to families who are faced with looking after orphans (Cook, Ali and Munthali, 2000), this is not felt to be the case by the majority of those families included in my research. While some families, such as those with children at Open Arms, obviously had knowledge of facilities and the wherewithal to access them, the majority rely on assistance from family and community members. When asked specifically if they had heard of any programmes that offered assistance to people with orphans, most replied that they had not. Of those who had heard of such programmes, the examples cited were primarily church and community-based efforts. One woman replied that she had heard of orphanages, and that they were a good means of '*civilizing*' children and teaching them to speak English, but she had no idea of how a person could go about sending an orphan to an orphanage, or where they were located.

The key idea in this section is that, notwithstanding the varied choice at an official level, individuals and families within rural areas (i.e. the majority of the population of Malawi) do not see that they have any choice in terms of how to care for the orphans for which they find themselves responsible. These orphans have been left by family members and are automatically incorporated into surviving family members' households (see Chapter 3). Refusal to look after an orphaned child is not an option –

not necessarily because of the reaction this would provoke from other members of the family/community, nor because of any particular sense of duty towards the dead kin or the orphans themselves. Rather, refusal is not a cognitive reality to most individuals. The concept would not be conceived in the first place, never mind be acted upon. This fact, along with a general lack of education and knowledge of orphan-related resources, means that most orphans are cared for within their own villages by members of their extended family. Furthermore, most respondents wouldn't even classify state-provided resources as potential coping strategies. There are, however, a minority who do access this help and there is anecdotal evidence to suggest that this number is increasing as traditional kinship ties are broken down by the onslaught of the HIV/AIDS epidemic, increasing poverty, and recurrent food crises. Thus, these sources of aid may become increasingly important to communities as their own resources are stretched to the limit. It is difficult to assess, however, whether such increased use of these institutions is as a result of there being an increased need for their services, or the result of the increased availability of such services as more and more institutions are established, and as they receive an increased amount of funding from international donor agencies and the Malawian government.

This chapter begins with a brief analysis of why some people successfully access external resources that assist them in caring for OVCs. The discussion then moves on, via the institutions of infant homes and orphanages, and the more recent phenomenon of 'children's villages', to kin networks and community-level resources, which are by far the most common sources of aid for OVCs. Various types of care are presented, followed by a more thorough comparison of these methods. Themes of comparison include the cultural acceptability of each mechanism, cost effectiveness, accessibility, quality of care, and the transitions between types of care. In conclusion the discussion focuses on the impact that such support mechanisms have had on communities as a whole.

Why do some people access external resources?

In Chapter 3, I explained that it is cognitively impossible for the majority of people I interviewed in villages to contemplate refusing to care for orphaned children from within their extended family. The extended kin network is so essential to the survival of households, and the community as a whole, that violating the rules of reciprocity and duty towards kin is virtually unthinkable. Yet infant homes, orphanages and children's villages are numerous and widespread in Malawi. They are full to capacity, and have to turn others away at the door. This raises questions as to the validity of the assertion that kin take care of kin. It does not, I believe, challenge fundamentally the ideal of the kinship network, however. The view expressed in Chapter 3 is true for the majority of rural Malawians. For those with more education than rural schooling however, or who live or have kin who live in an urban or peri-urban area, there is a wider range of options as evidenced by the various institutions discussed here.

It is important to note that I was unable to do a thorough analysis of the background of people who had children residing in the various institutions discussed in this chapter. Two factors were responsible. Firstly, some of the organizations would not release contact details for kin, due to issues of confidentiality. Secondly, children are brought from a wide catchment area to organizations such as Open Arms. Though the management of OA was willing to provide me with contact details for the next of kin, my several attempts to locate family members had little effect. Many had moved on since placing a child at OA. Others were simply inaccessible due to bad roads, long distances, and/or inadequate instructions for locating their houses. Eventually I interviewed only family members who came to OA itself. I spoke, therefore, to those members who had the financial resources to visit children, or who were there for the express purpose of dropping off a child. Evidence for the socio-economic background of families from other institutions is more reliant on second-hand information from staff working at these places, people more generally familiar with the organization, or other researchers with ties to the same organization.

The majority of children placed in institutions, I believe, come from a background where the family has the educational and personal resources to access such level of care, or who come from the community immediately surrounding the institution. Thus Memory, for example, is the child of a school teacher in Blantyre whose mother died giving birth to her. Memory lived at Open Arms for nearly two years. Children at SOS Lilongwe are referred by local social workers. They come predominantly from the Lilongwe community, that is, from people who have some familiarity with living in an urban situation (the capital city, in fact) where access to information about government resources is more readily available. Margaret, who currently resides at Kondanani Caring Hands, was brought to the home by her aunt who is a nurse at Queen Elizabeth Central Hospital. Of the institutions included in this section, only Open Arms receives a significant proportion of its children from rural areas. This can be attributed largely to the fact that Neville Bevis (the manager) drives to many villages to either collect or return children and, therefore, performs an advertising service in person. Word of mouth accomplishes the rest of the rural referrals to OA. Furthermore, OA is in the process of establishing a system of following up on children who have been returned to their families within rural communities, and this will no doubt further highlight OA as a potential resource to people currently caring for OVCs within their own family.

That people within urban and peri-urban areas have access to more information about what resources are available to those who care for OVCs is only partly related to an increased 'worldliness' evident in urban dwellers. In practice, such information is more accessible because people can actually see these organizations and the people working for them, therefore they can appraise such resources even without being more literate or educated in the ways of government. There is also some indication that urban dwellers have more circumscribed kin networks, and do not fall so readily into traditional habits of caring for extended kin. This breakdown in traditional values is often associated with a move into urban areas, and was one of the elements of 'Westernization' that Banda attempted to avoid by mandating ruralization for the Malawian population. Those urban dwellers who do maintain contact with their families in the village, may be able to facilitate the introduction of orphaned kin into

an organization established to aid OVCs. Thus rural families may benefit from these facilities more readily if they have kin who are located in urban areas and who have the knowledge that such organizations exist.

Categorizations of institutional care

Institutional care for OVCs is currently seen by many as an increasingly necessary element for a society like that of Malawi where the adult population has been decimated by HIV/AIDS. Previously, the majority of communities within Malawi were capable of absorbing OVCs and ensuring that they received adequate care and access to farming land. This is now becoming more difficult as the resources of individual families and communities as a whole are eroded. This erosion is largely a result of the devastation caused by HIV/AIDS, which predominantly affects economically productive individuals and the caregivers of children. In Malawi, the situation is exacerbated by the declining economy and repeated food shortages.

I discuss, below, several institutions with which I was acquainted during my research period, and provide a description of their goals and methods of operation. Two of these are infant homes (Open Arms and Kondanani Caring Hands) and a further two are orphanages that cater for children of all ages (Stephanos and Agape). A children's village, SOS Children's Village in Lilongwe, is also discussed briefly. Lastly, examples of community-based schemes to care for OVCs are provided.

Infant homes

Open Arms Infant Home (OA) is located in Blantyre, and is a bustling infant home always filled to capacity. There are 26 nannies, supervised by a Malawian matron, who provide care for approximately 40 infants at any one time, in three shifts around the clock. It is a registered charity in England and Wales, and receives extensive funding from the UK (the two expatriate managers, for example, are funded by Leeds United Football Club). OA also hosts volunteers from abroad who help with the tasks of looking after the infants. The majority of funding comes from private

donations and fundraising efforts conducted by schools in England with which the managers, Rosemarie and Neville Bevis, have contacts.

Usually, children must have lost their mother to be eligible for admission to OA, though on the rare occasion where a father has died and the mother is unable to provide for the children they will be accepted. All children remain at the home until the age of two. The rationale behind this period is that it is extremely expensive for a family to pay for infant formula for a child and that, without a breastfeeding mother and the money to pay for a breast-milk substitute, these children are at greatest risk of dying. Thus an infant home cares for them during these expensive first years and, when they are two years old - old enough to be eating the same food as the rest of the family - they are usually returned to their kin. Some, however, are sent on to orphanages, either because they were abandoned originally, or no surviving family members can be located. Unfortunately, the staff has witnessed a marked increase in the number of abandoned children being accepted at OA in the past few years. This is in large part due to the worsening socio-economic situation in Malawi and the HIV/AIDS epidemic, which have combined to place such stresses on the extended family system that it can no longer cope with the increased number of OVCs. A similar increase in child abandonment has been noted in South Africa. The South African National Council for Child and Family Welfare reported a 67% increase in the number of abandoned children between 1999 and 2002 (Desmond and Gow, 2002: 19). Adoption, which was previously an almost unheard of phenomenon in Malawi, is now being targeted as one means by which abandoned children can be cared for after they leave OA.

At any one time, there are several children at OA who are HIV positive, or who will probably develop HIV, since their mothers were HIV positive and they are still too young for tests to be conclusive. Hygiene procedures within the home are generally sufficient to ensure that cross infection of HIV does not occur between children, or between staff and children, but other infections are spread more easily. Colds certainly seem to be a permanent feature at OA, with quite a few of the children suffering at any one time. Malaria also occurs, despite the mosquito nets used while the infants and children sleep. The continuous illnesses are a feature of the close

quarters within which the children live, and are an inevitable result of institutionalized care.

An indication of the difficulties OA staff face with sickly children is the following example of Yohane, an HIV-positive little boy. Rosemarie tells his story as follows:

> *Yohane came to us as a very small unhealthy baby. His mother had passed away and he was diagnosed as HIV positive. His father, though sick, visited him once a month. Yohane was a sickly boy and never seemed to be without an infection of one sort or another. He was on regular doses of strong antibiotics and was often in and out of hospital. Yohane unusually remained at Open Arms until he was three. He required constant attention, often his oral thrush made it impossible for him to eat.*
>
> *He died of a combination of pneumonia and malaria. His father, who is now extremely ill, attended the funeral.*

Kondanani Caring Hands Infant Home (KCH) is another infant home located in Blantyre. It was opened on the 7th November 1998. The permanent manager of KCH is a Dutch woman, Annie Chikhwaza, who was previously responsible for opening a school for young children in Blantrye soon after her arrival in the country. After being implicated in witchcraft for poisoning her stepson, and almost killed by a mob intent on avenging his death, she was told to leave the country for her own safety. She stayed in South Africa for almost two years, but returned to Malawi to open an orphanage, this time in response to the plight of AIDS orphans that was beginning to be publicized around the world. Throughout 1998, using donations from churches in South Africa and the Muslim community in Blantyre, and with the help of various volunteers, a derelict house was transformed into the infant home. By the end of 1998 KCH was operational. The first child to be accepted, Deborah, died a year later from HIV/AIDS.

Unlike OA, KCH is a religious organization, which receives its funding through church bodies in the United States, the United Kingdom and South Africa. One of its

primary goals is the Christian education of the orphans: '*We sow the seed of the Word into their lives as one of the main ingredients of their upbringing. We want to see them develop as an asset to their community and this continent and by the grace of God we WILL.*[13]' This home cares for an average of 60 children at any one time, and has a staff of 50 nannies. Volunteers from missionary groups provide additional help. The majority of children at this infant home have been abandoned, and there are always several who are HIV positive. KCH, like Open Arms, has a high mortality rate for this reason. Children stay at KCH until the age of three, when they are either returned home to their families (not a very common outcome from this home) or sent on to another orphanage (in the past it was usually Stephanos). Due to the increasing number of children who aren't returned to their families, Kondanani has started construction of a Children's Village that will host children from the ages of three to six years in order to prolong their involvement with the children and reduce the stress on orphanages in the environs.

The KCH premises are significantly larger than those of OA, a necessity since they care for almost double the number of children. Volunteers from missionary groups (mainly Canadian) are housed regularly on site, and serve as temporary managers.

I visited KCH less often than I had contact with Open Arms. It is run in a similar fashion to OA, and faces many of the same challenges, particularly with regard to placing the children after their term at KCH is over and monitoring the well-being of those children who have been returned to their families (less of an issue at KCH since fewer children are returned). The new children's village may go some way towards alleviating the former issue for KCH, though the problem is simply postponed for a few more years, not resolved.

Orphanages

Two orphanages, Stephanos Children's Home in Chileka and Agape Orphanage in Blantyre are discussed here. The former is a well-established organization with years

[13] http://www.kondanani.com/Pages/Kond_CaringHands.htm

of experience working with orphans in Malawi. The latter was opened during the course of my fieldwork in Malawi and only became fully operational towards the end of my stay. The following descriptions are based on isolated field visits since, in the case of Stephanos (as for the SOS Children's Village discussed in the following section), the staff are wary of outsiders and do not welcome researchers. I was allowed a tour of both establishments, and spoke to some of the managers and carers at each location. I was not permitted, however, to talk to any of the children on the record, and did not conduct any participant observation. In the case of Agape, while I had continued contact with the organizer, the orphanage was only opened towards the end of my fieldwork period, thus I did not have much opportunity to observe its functioning.

Stephanos Children's Home is located on the outskirts of Blantyre and is a faith-based organization established in 1992 to care for orphans from the surrounding communities. In addition to the orphanage, it also teaches home-based care and has various community-based outreach activities in the areas of civic education and income-generating activities. The organization cares for approximately 100 children, and is an intermediate point between an orphanage and a children's village (discussed further in the next section). The resident children have housemothers. They attend the local school and have extra lessons on site. In 2001/2, the orphanage underwent a management change and has become more overtly religious and begun to move away from an orphanage-style set up (with dormitory rooms and communal living arrangements) towards becoming a children's village. Initially, this was the main recipient of children from Open Arms who had no family to which to return. The relationship between the two organizations is no longer as active due to the proselytising purpose of Stephanos subsequent to the management change.

Agape Home was started by a volunteer from Kondanani Caring Hands Infant Home (KCH), Diane. She volunteered at KCH for six months and, during that time, was so touched by the plight of the children who had nowhere to go after three years at the home that she decided to open her own orphanage for children of all ages. She returned to Canada for several months, during which time she raised sufficient

money to buy a property in Blantyre and to pay the salaries of several house staff. She returned to Blantyre in June 2002 and opened Agape Home. Initially, 14 children ranging in age from four- to thirteen-years-old were housed in two rooms. The staff consisted of two women who (with the help of some of the older children) cared for the children during the day, a cook, one woman who worked at nights, and a night guard. Funds are still in the process of being raised to ensure that all the children are able to continue at school. In the interim, they are being taught by Diane, who is a Sunday-school teacher, and they go to primary school – which is free.

Agape, too, is a highly religious organization. Diane, originally affiliated with a missionary organization, discussed her plans to open an orphanage with me in December 2001, before returning to Canada for her fundraising operation. She had been visiting potential properties in Blantyre in order to gain an understanding of the relative costs of different sized buildings, and had decided to go for one of the cheaper and smaller options, in order to have more money free for operational costs. When I commented on the size of the institution, Diane replied '*they have love and God's word. They don't need anything else*'. While I cannot comment on the quality of care provided to the residents at Agape, the fact that 14 children currently live in a house with two bedrooms raises the question of minimum standards. If the Malawian government had guidelines for orphanages and institutions that provide care for OVCs, limited ratios of children to bedrooms and bathrooms and staff to children would ensure a minimum quality of housing and care for all OVCs in institutions. This lack of legislation is a serious oversight and, while there are indications that such recommendations are in the process of being made to the Ministry of Gender, Youth and Community Services (Wiseman Chirwa, personal communication), these will take time to implement and enforce. In the meantime orphanages operate without any system of monitoring.

Other orphanages in the Blantyre area include the Jacaranda Children's home in Limbe, a communal home for forty children run by the Dutch Sisters of Mercy, and Yamikani House, where a lot of the children from OA are now sent. Yamikani received funding from DANIDA for a new building in 2002. The institution also

receives funding from its Board of Directors in Vermont and the Rotary Club in Vermont. Yamikani houses twenty children and provides day care, health check-ups, schooling and hygiene training for an additional 75 to 80 local children.

Children's villages

Children's villages are a relatively new phenomenon that arose as an alternative to orphanages for looking after vulnerable children. Following the Second World War in Europe there were large numbers of children without traceable family. Rather than condemning them to the type of orphanage present in Europe up to that point (reminiscent of 'Oliver Twist' style institutions), Hermann Gmeiner of Austria conceived of an alternate form of institution, the Societas Socialis (SOS) Kinderdorf. In this model, children are placed in homes within a specially-constructed village. In the charge of a 'house mother', siblings remain together. Each house will typically be home to about ten children. These children live together in as close an approximation of 'typical' home life as possible.

The SOS Children's Village in Lilongwe was established in 1992, and two years later began accepting children. The village has its own kindergarten and primary and secondary schools, as well as a medical centre (which also serves members of the surrounding community) and a vocational training centre. It is on the outskirts of Lilongwe, surrounded by a large security wall, and has gates manned by a security guard. The paved road, English-style hedges, signposts and carefully maintained brick buildings clearly separate it from the surrounding communities. The Village has various outreach projects to assist members of the surrounding community, including allowing some outside use of the village's health facilities and providing some agricultural extension activities. It is still clearly separate from this community, however. A security gate and guard limit access to the compound, and the lush gardens, immaculate buildings and other signs of wealth indicate the clear material gap that exists between the children in the SOS Village and those in surrounding communities.

There are twelve family houses on site, accommodating a total of 149 children. Each house has a 'mother' in charge, and there are 'aunts' who are employed to assist them. Mothers are women between the ages of 24 and 40 who, preferably, have had some education (although supplemental education may be provided by the village if necessary). They are single, widowed, separated or divorced, ideally without children of their own, or with older children. I was assured that none of the mothers currently employed in the Lilongwe village had their own children living with them. I was unable, though, to clarify if any had children living outside of the Village with other relatives. That the children have little contact with anyone other than staff, who are predominantly female, creates a somewhat artificially female environment compared with growing up in a rural village. Unlike the infant homes and orphanages where children are grouped strictly according to age, however, the mixed ages of children living together creates a more realistic household composition. The Village further allows for the close sibling bonding across age groups, which is a striking feature of kinship outside of institutional care. Without the opportunity to observe these households and children, however, it is impossible to say whether such bonding does take place, or whether the artificial nature of the kin groups has altered this pattern.

There is a second SOS Children's Village in Mzuzu, in the north of Malawi, but I did not visit this village at any point during my fieldwork. Further villages modelled on the SOS Children's Village, though not sponsored by SOS Kinderdorf, are being established throughout the country.

Non-institutional support mechanisms

As discussed previously (Chapter 3), the kinship structure in Malawi is still largely capable of absorbing OVCs and caring for them within the local community. This capacity is severely stretched, however, and cannot be expected to cope for much longer. As is obvious elsewhere in sub-Saharan Africa, even when traditional kinship structures are not the primary source of support for OVCs, they remain an important resource.

Despite the strain on kin resources, it remains true that cultural emphasis on accepting orphans is still strong. That Malawi is somewhat more 'traditional' than its neighbours due to the influence of President-for-Life Banda is also true. Its predominantly rural population has maintained its traditional culture and rural way of life for longer than have neighbouring countries where urban migration is a dominant theme of life. In response to the fact that the majority of orphans remain within their extended family, and within their own villages, communities are starting to accept help in order for this to continue. While international NGOs and donors emphasize a preference for this method of care, support has been slow to arrive. This is due largely to a lack of ideas as to how to effectively implement such assistance, and an unwillingness to change funding criteria to make it easier for community-based organizations (CBOs) to access grants and other support. Generally, though, communities have not stood still, waiting for such assistance to be delivered. Church groups, in particular, have organized themselves to provide care not only to orphans within their community but to the entire family affected by such orphaning. CBOs have followed suit.

The discussion below briefly outlines the role of the church in providing assistance to OVCs and their families, and then moves on to a discussion of the role of CBOs, using the example of the Songani Orphan and Community Care Group. The majority of the people I knew in Malawi are Christian, thus this section discusses the role of Christian churches in assisting people to care for OVCs. Islamic Mosques and Associations, however, play a very similar role for their members. Much of what is said here applies to both Christian churches and Islamic mosques. Indeed, in certain situations, the activities of the churches and mosques may overlap. The Songani Orphan and Community Care Group, for instance, receives support from both the Christian and Islamic communities since it covers an area where the population is split between followers of each faith. Eid and Christmas celebrations are open to all the orphans regardless of their actual faith, and are financed by the local Mosque and various missionary groups respectively.

It is important to note that there is a lot of overlap between community initiatives and religious networks. Many of the volunteers for the former hear about the opportunity, or organize the opportunity, through a church group. Funding and training for many of the community activities is also directed through church groups. Oftentimes it is difficult to distinguish between the community-level resources of religious networks and community-based initiatives.

Religious networks

Faith-based institutions provide a significant source of help for the community in a wide variety of ways. Church groups are the main form of social gathering (especially true for women) outside of immediate kin, and are therefore very important to the formation of social ties. A local church group would routinely be the second port of call for assistance should kin not be able to help, and the church is also the only form of social support routinely mentioned by interviewees as an option for assistance with OVCs. Churches are also a significant source of information for people regarding HIV/AIDS and social welfare so, for those people who do manage to access external means of support such as orphanages, it is not uncommon for them to be told about such opportunities by members of their local church.

Every village has a church or mosque (or both) the services of which inhabitants attend on a regular basis. Community-assistance projects and self-help groups usually draw their members from these, or else are channelled directly through them (particularly true of assistance from international missionary organizations). Emmanuel International (EI), for example, a Baptist missionary organization based in Zomba but with operations throughout southern and central Malawi, run a variety of development projects. Agricultural and forestry projects in Liwonde teach sustainable agricultural practices to local residents. Near Zomba is a home-based care initiative where carers receive regular training from EI. I attended a three-day AIDS counselling workshop in Kwitanda Village, Balaka District, hosted by EI for the local home-based carers, in order to supplement their skills.

An initial part of the training consisted of Helen, the trainer, asking the participants to list the kinds of 'people who counsel'. The list consisted of the following:

amayi (grandmother)
amfumu (village chief)
abusa (pastor/priest/reverend)
makolo (parents)
amalume (uncle)
aphunzitsi (teacher)

This illustrates neatly the reverence for authority. The above is the order in which the names were given, and through subsequent observation it is plain that it illustrates the ideal sequence in which assistance would usually be sought outside of the kin group, even for matters outside the counselling remit. Other persons in positions of authority, such as hospital personnel or government workers, are generally considered too remote, thus indicating the need for external institutions to be associated with a person with local authority in order to be more accessible to rural villagers. A keen concern with issues of hierarchy also ensures that people do not turn to outsiders for assistance before consulting relevant local parties in order not to offend the latter by insinuating that they are incapable of providing the required assistance. As CBOs become more widespread they may feature more prominently in the list of potential helpers.

Community-based initiatives

Until recently, kinship networks were largely capable of absorbing orphans into the extended family, so there was little need for external assistance targeted at this problem. Increasing impoverishment of families, however, which is associated with increased mortality, the HIV/AIDS epidemic and national financial policies, has reached the point where families are no longer capable of responding to the orphan crisis without external assistance.

To illustrate just how the coping mechanisms of both individuals and families can be overwhelmed by the impact of orphans, the following kinship diagram of a case-study family is presented:

FIGURE 11: KINSHIP DIAGRAM, EDITH MOSES

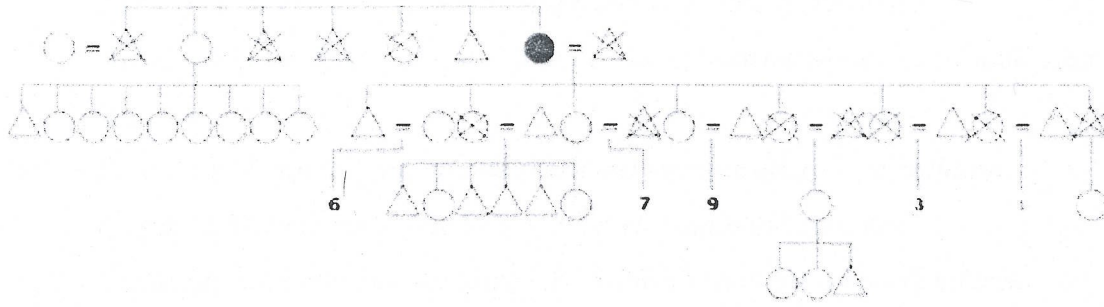
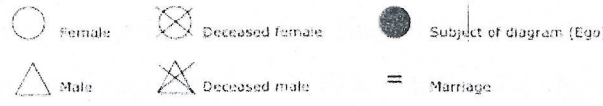


FIGURE 12: KEY TO KINSHIP DIAGRAM



Edith, an elderly woman recently widowed, is faced with a staggering number of orphans in her family. She is also the only person to have indicated a refusal on the part of her kin to provide assistance. This refusal came from the fact that others in her family were so poor that they could not accept any additional burdens. This family has obviously reached breaking point in the struggle to care for orphans. The following conversation outlines the refusal of her kin to provide further assistance to her and her orphaned grandchildren:

> Question: Is their father contributing help?
> *Edith: No.*
> Question: Why not?
> *Edith: My in-law hesitated.*
> Question: Why?
> *Edith: He said he did not have anything to give the children.*
> Question: It is possible for someone to refuse (to care for orphans)?

Edith: Yes my daughter refused to help me.

Question: What makes a person to refuse?

Edith: Being poor.

Question: I understand everyone in the village is poor. So why did others refuse?

Edith: I don't know, but I am selling bananas for husks or maize.

Question: Does financial status matter when choosing someone to look after orphans?

Edith: Yes, I can tell you no one's helping me look after these children.

Question: Did anybody else help you when your child was sick?

Edith: My daughter but she stopped, saying she has got a lot of children.

This scenario of kin refusing to provide assistance for the care of orphans is likely to become increasingly common as individuals reach the point where accepting responsibility for even one more orphan is a financial and emotional impossibility. It is in such situations that assistance from CBOs can make a significant difference in assisting individuals to provide care for kin, thereby preventing the breakdown of families and social structures.

The Songani Orphan and Community Care Group (SOCCG) is a CBO that was initiated in 1996 by Mr Kennedy Mpoya. Consistent with the cultural praxis of extended families in Malawi, the organization supports families who have adopted AIDS orphans rather than sending them out of the community and their local culture. Elderly widows with minimal income are the main caregivers for the 410 orphans currently receiving help from the organization. The main objective is to keep local orphans in their normal community and extended family to avoid 'institutionalization' and maintain cultural continuity.

Mr Mpoya describes the history of this group as follows:

So after I left Zomba Central Hospital, I went to St. Luke's Hospital where I was still doing the counselling and that thing was growing in my mind that I have to look after orphans and later on, we had my sister-in-law who passed

away and left her kids and I was keeping those kids in my house. So that thing grew up and it grew and later on that is when I started coming to this option that what about if I start an Orphan Care Centre. I will be going out to Zomba Central Hospital or other places, helping those orphans or what about if I can do that in my area where I am coming from, where I'm living, and I started this Care Centre. Before I started it, I went to the Village Headman and I spoke to him and he gave me an OK and I came back and I did some majorities that we have. In the '90s people who started with me only few were doing in the group because they thought they are going to get something from it. The way it started, we were contributing money, maize, salt and giving them to elderly widows and that's how it started. So the thing is, I was brought up by my mother and I was also an orphan for some few years because my dad left me when I was six.

The major attribute of SOCCG is that it was established by a member of the local community. For several years it was self-funding. Adults within the community itself were asked to contribute 5 kwacha (approximately £0.05 at current exchange rates, though as much as £0.15 five years ago) a week to a central fund. This fund was then used to purchase supplies of maize and soap, which were subsequently redistributed to families within the community proportionate to the number of orphans living in the household. Following two years of poor harvests and a generally worsening economic situation concomitant to an increase in the number of OVCs, the group could no longer afford to support themselves and donations were solicited from the expatriate community in Zomba. These were forthcoming. A community centre was built with the proceeds of one donation, and maize distributions were an ongoing feature. The reliability of such funding, however, is questionable. This is not an ideal situation.

SOCCG has subsequently evolved into an established CBO. It has a core group of volunteers who manage the day-to-day running of the group's facilities, operating a nursery school and providing training in a variety of income-generating activities that include carpentry, tinsmithing, and instructing women on the making of briquettes to sell and/or use as fuel substitutes. Recently added initiatives include

training in mosquito-screen construction, and soap- and candle-making. Previous grants from War on Want, donations from individuals, and volunteer efforts have sustained the group to date. It is hoped that some of the ongoing activities will provide income-generation not only for the participants but for the group as a whole in order to promote its self-sufficiency.

This was the only example of a fully functioning, locally initiated organization that I found within the Zomba area. I have been told that there are several similar organizations around the lake and in the north, yet they are generally the exception rather than the norm. SOCCG's success can be attributed largely to Mr Mpoya's political savvy and his connections (he has both a brother and a sister who work for the ruling UDF), as well as his commitment to the group. The group is also well placed to benefit from interest and funding on an ad-hoc basis from the expatriate community in Zomba. Despite the obvious successes of the group, however, funding remains a problem. Grants from War on Want are piecemeal: short-term funding for specific activities that must be disbursed relatively quickly. Then, once the specific activity is over, further applications for funding are required. What is needed, more than funding for additional 'projects' (invariably taking the form of additional vocational training) is a long-term commitment to support the group as a whole. Examples of such commitment could be: salaries for a core group of people who currently volunteer their services to run the group, insurance and technical support for the central credit fund which the volunteers are attempting to maintain, outreach to educate the group about available funding opportunities, and an understanding that families are not going to be drawn out of poverty within the one- to three-years project-funding period common to small grants. Crucially, a genuine lack of pride on the part of the donors is necessary: SOCCG volunteers know what they would like to accomplish and they understand what initiatives will succeed in their community and benefit the greatest number of families. Donors need to be able to accept the role of *dictated to* rather than *dictator*, and work simply as channels of funding and technical support.

Comparing methods of caring for orphans and vulnerable children

Given the wide range of methods used to care for orphans and, in some instances, the extended families who are affected by the increased number of orphans it is necessary to compare these processes in order to comment on their effectiveness. In the following section, some of these comparisons are discussed with respect to issues of accessibility, cultural acceptability, the quality of care provided, cost effectiveness and funding concerns, and transitions between types of care.

Accessibility

As mentioned earlier in this chapter, observations suggest that urban dwellers with at least some education are more likely to access external care resources provided by institutions such as infant homes and orphanages. This is potentially true also of SOS Children's Villages since, most frequently, children are placed there after the death of a mother in hospital. Since 81.9% of women in urban areas give birth within a health facility, as opposed to 51.6% of rural residents (Malawi Demographic and Health Survey, 2000: 109), it is probably true to say that those who access health care resources, particularly in a city such as Lilongwe, have the resources and education to do so. This differentiates them to some degree from the majority of the population - rural Malawians. Some of the aids and constraints to accessing the resources outlined in preceding sections are discussed here, providing a comparison between the different available mechanisms.

Open Arms accepts infants from all over Southern Malawi. The orphans are usually referred to the home by the District Social Welfare Office (DSWO). There are, however, instances of self-referral from villagers who have heard of OA from someone who has used the facility. Furthermore, when Neville visits a village in order to fetch or return a child, others in the village often approach him, looking for help with the orphans in their midst. He points out that 'whenever I go into a village to pick up one orphan, there are always others around asking me to take their children as well because they can't care for them any longer. It's especially bad during the hunger months.' In instances of self-referral, the Social Welfare Office for the district is contacted, and the caregiver undergoes a brief interview before

relinquishing the orphan to OA. While the institution tries never to turn down a child, this must occasionally be done because it is operating at full capacity. The DSWO may refer the caregiver on to another organization, such as Kondanani, but more often than not the person is sent home to manage as well as possible, and no follow-up is available to assess the outcome of such a rejection.

In their search for care options for orphans, relatives may go to extraordinary lengths to place a baby with OA, as Rosemarie's story indicates:

> *One Monday morning as we were opening the office at 7am we were greeted by a young girl of 14 or 15 years. The ragged bundle she was carrying in her arms turned out to be her twin nephew and niece. They had spent the previous two and a half days on buses travelling from Mzimba, which is 350 miles to the north. Their mother and father had both died and there were a number of older siblings left parentless in their village. There was no food, so the villagers who had heard of us some how clubbed together for a one-way fare.*

Both Kondanani and SOS accept children referred to them by the DSWO, though like OA they also have people that try to hand over orphans directly at the institution. The PR Manager for SOS assured me that the majority, however, come through official Social Welfare channels, thus '*ensuring that they are the neediest children*' – an assertion I would challenge, since those who can access Social Welfare services are often better off than those who do not have the knowledge or wherewithal to make this contact. Furthermore, in making a distinction between 'needy' children, it is extremely difficult to differentiate between degrees of neediness: the majority of orphans live in varying degrees of poverty, all of which are threatening to the child's health and well-being. Such levels are seldom static. Any attempt to distinguish between levels of extreme poverty, absolutely none of which are desirable, makes the job of turning children away heartbreaking, since it is obvious that there is still a huge unmet need for assistance.

I interviewed one, Delex Mandikisi, father of Norman who was in the care of OA. The interview took place in Bangula, on the southeastern border of Malawi with Mozambique, and five hours drive from Blantyre. The hospital where Delex worked served people from both Malawi and Mozambique. Delex described his decision to place Norman at Open Arms as follows:

Question: Why did you send Norman to Open Arms after the death of his mother?

Delex: Norman was very young that I couldn't manage to keep him as he was a month and 2 weeks old.

Question: Who made the decision?

Delex: My friend told me to consult the sisters of Kalemba hospital so that they can help me but he did not know about the Open Arms.

Question: What kind of transport did you use to Blantyre?

Delex: We used the car from Kalemba.

Question: When deciding where to put a child after his mother's death does the age make any difference?

Delex: They did not tell me about this but only said that I am supposed to be visiting Norman whenever I get something to give him but am not going due to lack of money.

Question: If you had money would you go?

Delex: Yes.

Those relatives of children in OA who did visit the home often expressed the desire to do so more frequently but lack of finance prevented from so doing. Fathers, like Delex, who lived too far away to visit even once during the child's two-years stay at OA also expressed regret that financial considerations did not allow them to see their child. This is perhaps the key feature of accessibility to the institutions discussed in this chapter, namely, their geographical location. Situated as they are in Blantyre and Lilongwe, these immaculate buildings with high security fences and fine on-site accommodation for (predominantly) expatriate managers, allow for a life of relative luxury while still maintaining the guise of charity. Location is chosen more for the

convenience of staff than for the convenience of the population they ostensibly serve. There is an argument for institutional care as a last-ditch resource (Barnett and Whiteside, 2002; Phiri and Webb, 2002), however such institutions would serve their function better were they to be located in rural areas where the need is greatest. The establishment of a limited number of institutions in rural areas, where they could be managed by the communities themselves or perhaps by church groups, would serve as back-up to community-based attempts at supporting OVCs, as well as create employment opportunities in rural areas. The needs of the orphans themselves would also be better served by allowing them to grow up within a community with realistic ideas of what their future holds, and enabling them to maintain cultural and kinship ties.

Despite a Zomba DSWO, hospital personnel and, of course, staff at various institutions citing orphanages and children's villages as would-be sources of aid to villagers with OVCs, rural Malawians themselves do not classify these as potential resources. When asked, the majority of interviewees responded that they had no knowledge of institutions that could provide assistance. Those few who did know of potential sources of help, invariably referred to their local church or the Songani Orphan and Community Care Group rather than to institutions in urban areas. It remains true that despite the recent proliferation of such institutions, they are inaccessible and unknown to rural Malawians. Thus they cannot be counted as a coping mechanism for the majority of the population. Kin networks remain the predominant source of assistance.

Cultural acceptability

A resource common to North America and Europe, namely, the adoption of orphaned children, has not been discussed so far in this thesis. This lack of attention is due mainly to its rarity in Malawi (at an official level and outside of the extended family). Due to the general lack of experience with formalized adoption, there are institutional and legal barriers to this that so far have prevented it from becoming a regular means of caring for children. The incorporation of orphaned kin into a household is usually accomplished without any recourse to official channels.

The fluid nature of many households and families is a key characteristic of families in Malawi, and is due to a combination of factors. Poverty is a prime cause of this fluidity. During crisis periods, children may be fostered out to relatives who are better off. Children may also be used as workers in households of their extended kin if their own family is having difficulty supporting them. Adult members of a household/family may travel extensively for work and may be absent for significant periods of time. High death rates also promote a constantly shifting household composition, as do high incidents of illness, in response to which a member of a household may move to provide care or agricultural support to a sick family member. All of these factors contribute to the changing composition of households, changes that may last for significantly long periods. A child could be living with relatives for most of his/her life without there ever being any formal transfer of guardianship, either through traditional authorities or government channels. That this situation is so prevalent in Malawi, combined with the fact that so many families are caring for OVCs already, or anticipate so doing, makes official adoption an unlikely solution to the problem of OVCs who do not have any kin to care for them. Thus other mechanisms step into the void to provide a care structure for these children. The cultural acceptability of other forms of assistance is higher than that of official adoption and is discussed below.

At the policy level in Malawi, there has been little discussion of the cultural acceptability of institutional care. Interviews with people who have children in institutional care, as well as with those who don't, suggest that there is no aversion to this practice. In fact, several interviewees commented on it favourably, primarily because of the association of such care with white (and therefore, rich) people. Thus, institutions are perceived to 'civilize' children by making them more like *azungu*. Institutions are not well-understood by rural people, but they associate them with positive traits, in comparison to the 'suffering' that children undergo growing up within a village. It is easy to understand the attraction, for people whose main concern is finding sufficient food for themselves and their family, of an institution

that feeds children regularly and clothes them to a standard seldom seen within a village.

As Maslow's (1968) hierarchy of needs suggests, it is difficult for parents who struggle on a daily basis to feed and clothe their children to make the emotional wellbeing of a child or its potential future cultural alienation matters of pressing concern. That institutions and the *azungu* who run them are seen in almost heroic terms is a drawback. The assumption that children will be well fed, clothed and educated in an orphanage is widespread, even among people who have never seen such an institution or heard reliable reports to that effect.

That Malawians do not object to orphanages in the abstract, however, does not mean that there aren't objections to be made on cultural grounds. Institutionalization has been shown to be detrimental to the long-term development of children and is associated with a wide range of social problems, particularly, a decreased ability of these children to function in their cultural milieu (e.g. Children and Family Justice Center, 1995; Donahue and Williamson, 1996 and 1999; Hunter, 2000; Children's Rights, 2003). While few long-term studies of the impact of institutionalization on children in African societies have been carried out, due mainly to the rarity of the practice in the history of most African cultures, Phiri and Webb point out that:

> Children in institutions have tenuous cultural, spiritual and kinship ties with families, clans and communities. These ties are especially critical in Africa and Asia as they are the basis for people's sense of connectedness, belonging and continuity. They are the basis upon which life skills as well as social and cultural skills are attained. Children raised in institutions struggle to be accepted or fit into traditional rituals and ceremonies as well as contracts and alliance arrangements. The feelings of ostracism these situations engender further adversely affect psychological and emotional well being. It may also be the case that children raised in institutions may likely look down upon their own communities as being inferior after getting used to the trappings of an institution – especially the kind that provides a materially high, western standard of care. (2002: 15)

Furthermore, 'it is clear that (institutions) would significantly contribute to the undermining of more 'traditional' community coping processes' (ibid.). The extent to

which traditional coping mechanisms have been undermined by the accessibility of alternate (externally imposed) care strategies is difficult to assess, and there is a distinct lack of longitudinal studies on this issue because of the relatively recent nature of the phenomenon. It is clear in Malawi that these institutions will not meet with local resistance, due to a widespread reverence for white people and their cultures. This is particularly true because the majority of Malawians are intensely religious and see white people and missionaries as largely synonymous. This attitude is encapsulated by the approving comment of a lecturer at Chancellor College, that '*Christianity is making much progress in eliminating local cultures*'. Orphanages and other institutions aimed at caring for OVCs outside of the local community have the approval of many Malawians, and can be said to be 'culturally acceptable'. Their detrimental impact on local coping strategies is undeniable, however, and only likely to become more profound. Should NGOs and other organizations providing these services commit to supporting local efforts that deal with the increasing number of OVCs, they would encourage local pride and resilience and have a more positive impact on Malawian culture.

Were orphanages to be more widely understood, and perhaps better positioned for rural access and cultural continuity, their negative impact on the enculturation of future generations might be mitigated. As it stands, however, institutionalization serves the survival needs of orphans, but not their emotional or cultural needs. Its effect is probably least in orphans who return from infant homes to be reincorporated into their extended family. The psychological effects of such dislocation and detachment have not been evaluated, though, so it is impossible to state this with any certainty. Extended periods in orphanages, however, may result in a generation of children with no understanding of how to survive as Malawians within their own country. This problem has not been encountered yet because the first generation of orphans who have grown up almost entirely in institutions is yet to reach the age where they leave their institutional home. Future research will be necessary to evaluate the true impact of such institutionalization on both orphans and the communities in which they reside.

Quality of care

In 1997, Malawi had ten official orphanages. A message on the ProCAARE[14] bulletin board highlighted the inadequacy of this number to deal with the increasing number of AIDS orphans in the country:

> 'Malawi: Extended Family Overwhelmed by Orphans' (04/18/97)
> Widespread incidence of AIDS and official disdain for orphanages in Malawi are contributing to an escalating crisis regarding child supervision in the country. According to the National AIDS Control Program, AIDS could orphan as many as 30 000 children by the year 2000. Meanwhile, the impoverished state government refuses to augment the nation's 10 existing orphanages for fear that they stigmatize children and break up the family. (CDC AIDSNews, 1997[15])

Since then, however, the number of orphanages in Malawi has increased dramatically – to the point that there are no official estimates as to the number currently in operation. While there is a limited amount of paperwork to be completed for the Malawian government in order to establish an orphanage, this is not significant and in no way regulates the establishment of such institutions. With the vast amount of funding available for programmes aimed at OVCs, and in particular AIDS orphans, this situation lends itself to exploitation by the unscrupulous. The proliferation of orphanages is beginning to be acknowledged as a problem by the Ministry of Gender, Youth and Community Services, which, in August 2002, initiated a 'crackdown' on those that were not providing adequate facilities for the children under their care. On 31August 2002, Rais reported in *The Nation* as follows:

> Mzimba: The Ministry of Gender, Youth and Community Services is on a countrywide crackdown campaign on orphanages with poor facilities and services which are said to be adding injury to the already destitute orphans.
>
> On Monday, Director of Social Welfare Services, Penstone Kilembe ordered the immediate closure of Mzimba orphan care after an inspection with officials from the District Assembly, Police, Health and Media which revealed that the place was inhabitable apart from

[14] Program for the Collaboration Against AIDS And Related Epidemics

[15] http://www.procaare.org/archive/procaare/199704/msg00026.php

> failing to offer adequate meals, beddings and health attention among others.

It is still too early to judge whether or not the government's focus on orphanages will promote higher standards and legitimacy of enterprises - there have been instances of orphanage funds being stolen by a member of staff, necessitating the closure of the orphanage (an example of which was reported by Lacey in *The New York Times*, 10 July 2003). It is safe to say, however, that the government no longer has the attitude of 'official disdain' for orphanages that is reported above. Such disdain may have been a remnant of former-President Banda's insistence on maintaining a 'traditional' Malawian society by keeping populations in rural areas and dependent on subsistence agriculture, and by enforcing strict and highly conservative bans on Western influences that might undermine the Malawian social and kinship structures. As has been mentioned before, the local kinship structure has been capable, to date, of absorbing orphaned children while maintaining its resilience and capacity to respond to external stresses. Unfortunately, the HIV/AIDS epidemic and increased poverty levels have undermined this capability to the extent that it is no longer realistic to assume that organizations external to the kinship structure are unnecessary, or that they have a significant role in destabilizing these same structures. There is, however, some validity in the concern that these external organizations – infant homes, orphanages, and children's villages – do damage the kinship structure. The displacement and dislocation of children from their home villages also threatens cultural continuity and inheritance rights.

Government regulation of institutional care for OVCs is a crucial step in ensuring a minimum standard of quality of care. As Landgren states in a UNICEF memo:

> The issues of fostering, institutional care and adoption have all been addressed by the Committee on the Rights of the Child. Institutionalization of children has come in for particularly severe criticism: commenting on a number of State reports, the Committee has noted the high mortality rates among children in institutions, as well as numerous issues of neglect and maltreatment. The Committee regards institutionalization as a last resort. Fostering and adoption are to be regulated by law and supervised by a competent body. (1998: 3)

Yet it must be acknowledged that the government in Malawi simply does not have the capacity to enforce any regulations. This is true at all levels. For example, the Zomba District Social Welfare Officer does not have any transport to visit families, and, at the national level, government ministries are losing experienced colleagues to HIV/AIDS at an alarming rate, further undermining the efficacy of the government as a whole.

Despite this failure of regulation, however, the majority of institutions do provide high quality of care to their orphans, though this standard of care is too often based upon Western, non-Malawian ideals and standards. The question remains, therefore, whether these resources might not be better allocated and prove more effective elsewhere. In the next section, cost effectiveness and funding in relation to the care of OVCs are discussed and consideration is given to where injections of funding would make the most difference to communities confronting the growing crisis of OVC support.

Cost effectiveness and funding

Despite the proliferation of orphanages, it is generally agreed that supporting community-based efforts is actually more cost effective than the construction of institutions that can only care for a very finite number of children. A comparison of the cost effectiveness of various methods of orphan care in South Africa is shown in the table below:

TABLE 2: COST EFFECTIVENESS OF SIX MODELS OF ORPHAN CARE IN SOUTH AFRICA

Model of care	Cost per childcare month (SA Rand)	Cost per min standard childcare month
Statutory residential care	2938 (3873*)	2590 (3525*)
Statutory adoption and foster care	609	410
Unregistered residential care	996	957
Home-based care and support	506	306
Community-based support structures	**	276
Informal fostering/Non-statutory foster care	**	325

Notes: *including medical costs associated with the child's HIV-positive status
**fail to meet material minimum .
(Source: Desmond and Gow, 2001, as cited in Phiri and Webb, 2002: 19)

The data demonstrates clearly that not only does home-based care and support for OVCs cost significantly less than residential care on a monthly basis, but so do a wide variety of alternatives. Taking into account that residential care is necessarily limited in its scope, the argument for supporting community care mechanisms and forms of foster care is overwhelming from a cost-effectiveness standpoint. Institutions can accommodate fewer children than many other forms of care, and have high overhead and maintenance costs - ongoing costs routinely higher than those associated with CBOs. In another report, Bhargava and Bigombe estimate that the costs of institutional care 'in Malawi ranged from US$250 to US$1700' (2003: 1387) per capita on an annual basis. They go on to point out that 'an annual subsidy of US$100 to fostering households would cover the additional expenses of caring for infants' (2003: 1388), clearly making the latter a preferable financial option.

Institutional administrative costs add to the cost of caring for a child, and take donor money away from the beneficiaries. SOS Children's Village in Lilongwe, for example, has an annual administrative cost of US$64 per child, compared with the US$53 per child spent on food and shelter (ibid.). In community settings, these administrative costs would be significantly less, thus ensuring that more of the money is spent on needy families and children than on administration.

Cost-benefit analyses and cost effectiveness do not, of course, provide the whole story. As Barnett and Whiteside eloquently point out, 'a foster parent provides care and support and (a) parent provides love as well. Can money buy love, how do you cost a cuddle?' (2002: 14) Furthermore, it is in homes and communities that 'social reproduction occurs at its deepest level: in the stories told by parents and grandparents to their children, in the giving and receiving of affection, in the taking and relinquishing of responsibility.' (ibid.: 15). Community support mechanisms usually arise out of a real need on the part of a community, and utilize innovative coping mechanisms that are situation-specific. Such solutions are thus more sustainable and effective (e.g. Foster, 2002). These elements do not appear on tables like that reproduced above, yet they are extremely valuable to OVCs and communities as a whole.

The cost argument in favour of community-based care for OVCs is so overwhelming that most international donors and non-governmental organizations insist that their intent is to support such mechanisms in preference to residential care. Yet funding for community programmes lags behind such commitments, while institutions are springing up at an increasing rate. The gaping discrepancy between ideological commitment and practical, financial support is clear. As Foster states

> In spite of rhetoric to the contrary, little external assistance – technical or financial – has actually reached community groups. Less than 30 percent of U.S. funding for foreign assistance is actually spent outside the United States, and only a fraction of this amount is spent within affected communities by the organizations that have been contracted to implement programs of assistance. (2002: 1908)

The key element in this discrepancy is the procedure necessary for CBOs to access financial assistance. These grants involve complicated application procedures, often using inappropriate mechanisms. Applications for grants on behalf of SOCCG, for instance, involved long forms that had to be completed in English. No allowances were made for other languages, despite the fact that Chichewa is Malawi's official language! This requirement, reminiscent of Banda's English language requirement for government candidates, effectively excludes the vast majority of the population from accessing such assistance. In some instances, applications are even required to be typewritten or word-processed. While often there are individuals in market places who can type a letter for a fee, this is an unnecessary expense for the applicant.

Even when the application procedure is accessible, however, the scope of funding from international donors is usually for short time frames and for project-specific activities. Thus, income-generating projects such as carpentry, wood-carving and briquette making are popular throughout Malawi. These projects can be implemented over short periods and yield the concrete results required by donor accountants: x number of children trained in y skill. Yet the very popularity of these programmes compromises their success. Carpentry and wood carving have not only encouraged further deforestation, but have resulted in a market glut of products, all of which are

routinely cheap and do not sell for sufficient money to profit the carver. Briquettes, marketed as an alternative to wood for fuel, are highly unpopular. Women object to their smell, and also to the fact that they must be bought when firewood can be gathered free. Furthermore, scavenging for paper and sawdust to be used in making the briquettes is not an easy task and is very time consuming. It jeopardizes the farming activities that most people rely on for subsistence.

SOCCG illustrates the difficulties CBOs face in seeking funding for on-going activities. A lack of finances is an issue of constant concern. There is no consistent, long-term source of money, and most of the donations occur on an *ad hoc* basis, not allowing for sustainability. Furthermore, despite the fact that 410 orphans and their families are currently receiving assistance from the group (in an area of approximately 25 km^2) there remain a significant number of orphans (Mr Mpoya estimates at least double that number again) who are excluded due to financial constraints. Official grants from donors serve to maintain a specific activity (e.g. training orphans in the necessary skills to design and make mosquito screens for doors and windows) for a limited period (three months in this instance). When each project is completed, there is a scramble for more funds to start a new one. Few donors wish to fund an existing activity. The time commitment involved in securing the limited funding for these short periods is immense. SOCCG's success is only because Mr Mpoya has a pension from a previous job – a luxury unavailable to most people – and can therefore operate the project full-time.

The majority of donors profess a preference for funding community-driven and –based initiatives; the following statement by UNICEF is typical:

> Institutionalized care for the majority of orphans and other affected children is not an appropriate option. Resources are more effectively used in strengthening the abilities of families and communities to care for orphaned and affected children in their midst. Where institutional care is offered, programmes must be developed to integrate children back into their communities at the earliest opportunity. (2002: 1)

Yet most donors find it difficult to provide funds to organizations that operate on such a 'small' scale, and which do not have the infrastructure and hierarchies present in externally driven development projects. Funds may be mobilized in the form of short-term grants of US$500 - 100 000 from various donors, but these are activity-specific and time limited. Ongoing financial support of similar value on an annual basis is rare, and the administration of such is fraught with difficulties (as discussed in the following chapter). The majority of grants received by SOCCG were prepared and presented on behalf of the organization by expatriate volunteers, hardly a sustainable method of funding the group, and one that does not build capacity within the organization itself. Without someone with experience at accessing such funding opportunities, and without a computer or anyone with computer skills, grassroots initiatives have no means of accessing funds. Assistance from outside the group is required. Donor agencies do not seek out CBOs in need of financial assistance. Instead, they prefer to either create their own CBOs from scratch (thus undermining local coping efforts), or wait to be approached.

Even the World Bank (1997) acknowledges that, ideally, funds should be channelled through local communities in order for these funds to most effectively address the problems of OVCs. At the same time, however, it insists that projects be 'scaled-up' to an extent that they have a more measurable impact. NGOs, too, find it difficult to support an initiative such as SOCCG, since there is no formal management structure, there is no bookkeeper, and there is a general lack of Western-style office culture. Barnett and Whiteside point out that:

> ... the scale is too small and variability in circumstance too great to be covered by large programmes. The great danger is that it is here – where it is most needed and where the very long term costs are stacking up – that response to impact will be impossible because there is no way of dealing with small scale and large variability. This is a major policy challenge. (2002: 14)

It is a major policy challenge that has not yet been addressed by donors, but one that is in urgent need of attention. As Cook (1997) states, and as this thesis has maintained throughout, 'the healthiest children (are those) in communities where

local support systems and those provided by the government (and donors) complement one another[16]'. Donors must be willing to make long-term commitments of smaller amounts of money to supplement community safety nets, and be prepared to do so for decades rather than the months-long time scales currently in operation. The benefits and drawbacks of operating through CBOs to provide assistance to OVCs are discussed in greater detail in the following chapter.

Unfortunately, there is a further impediment to the support of CBOs in the form of international support for orphanages. All of the institutions mentioned in this thesis were initiated by foreigners in response to a perceived need for institutional care, and often with very little prior experience in Malawi. One illustration of this comes from a situation I experienced in Zomba:

> A wealthy benefactor from the Lutheran church in Wisconsin wanted to establish an orphanage in Malawi. He had US$15 000 to invest initially, and would commit to providing an additional US$3 000 a year indefinitely. He and his wife had been to Malawi once, to visit some missionary friends, but this was a brief visit several years previously. He was relying on local missionaries to scout for a location for the building, arrange for its construction, and to identify 25-30 orphans to live in the orphanage. He returned to Malawi in June (2002), bringing the money with him. Cathy had asked if I would discuss my research with him and help the pastor of the local church to convince him that such a sum of money would be more effectively used elsewhere, for instance by supporting the local church group in their orphan care initiatives which reach a wider audience.
>
> When he arrived, however, he refused to listen to advice from either the pastor or the head of the local Lutheran missionary unit, and I never got a chance to meet him. It was obvious he was not taking anyone's advice on how to spend his money. He chose a plot of land near the church for his

[16] http://communications.uvic.ca/ring/97nov28/InternationalReport/Researchwillassist.html

> orphanage, and he and his wife laid the first bricks of the foundation. They provided a brass plaque with their names on it to be displayed upon completion of the building, which is due in September. He plans to return at Christmas time with presents for the orphans and, apparently, also plans on bringing an American turkey for the celebration.

This insistence on the part of outsiders to provide funding for institutional care is an issue of growing concern to development workers. It is a topic of ongoing discussions on both the CABA and Af-AIDS on-line forums. Most recently, John Williamson and Neil Monk (see Appendix 5) have both reacted to an article in the Washington Post, entitled *A Generation Orphaned by AIDS* (Wax, 2003*a*). They point out that articles in this genre give Americans the impression that there are simply no functioning adults remaining in Africa because they have all succumbed to HIV/AIDS, leaving a generation of orphans without any caregivers. Thus it is only logical that the majority of funds coming from the USA (raised predominantly on an individual basis through church groups and schools) are targeted at the establishment of institutions to care for these abandoned orphans. That the extended family system is struggling to survive, and the majority of children are still cared for within these families, is glossed over in favour of sensational reporting. The New York Times, for example, presents articles that focus on the fact that 'AIDS wiped out entire Ugandan villages' (Miller, 2003: B7), or which ask 'What will become of Africa's AIDS orphans?' (Greene, 2002: 50). The Washington Post, slightly more conservative, reports approvingly on senate funding for abstinence programmes in Africa (Dewar and Eilperin, 2003: A4), while highlighting the deviant sexual practices (Wax, 2003*b*: A12; Milloy, 20 August 2003: B1) that have created a generation of orphans. Together with official reports from organizations such as UNAIDS and UNICEF, these articles result in a collective ignorance of the reality of orphan-care in Africa, and contribute to the proliferation of institutions that are undermining the extended-family system in countries such as Malawi.

One final point regarding the cost effectiveness of institutions versus community organizations should be made: that is, institutions focus on helping individuals,

whereas community organizations tend to regard the OVC problem in a more holistic fashion. Thus, SOCCG for instance, aims to help the entire family affected by absorbing an orphan. The fortnightly maize distributions during the hunger months are a prime example of this. They are used to supplement the nutrition of families who are caring for orphans. While families have to be actively caring for orphans to benefit from the scheme, the increased food supplies are to supplement the requirements for the household as a whole – counterbalancing to some extent, the fact that the entire household pays when orphans arrive. Along with the maize, infant formula (where applicable) and soap are also distributed to the families. Additionally, the volunteers conduct HIV/AIDS education programmes, and offer some home-based-care assistance. For less cost than it takes to run an institution that has a strictly limited beneficiary group a CBO, therefore, can improve the living standards of all children affected by AIDS (directly and indirectly) as opposed to the more limited category of orphans.

Transitions between types of care

Institutionalized orphans are faced with the prospect of either returning to their family after a few years (as in the case of infant homes), or transferring to an alternative care institution – e.g. an orphanage or children's village from an infant home. This section focuses on the transitions from infant home to village and within the extended family. SOS Children's Village has yet to have any orphans 'graduate' from its care, and the children's village at Kondanani had not yet started operating during my time in Malawi. Moves from infant homes to orphanages did occur while I was in Blantyre but, since I did not have a very good research relationship with the orphanages, I had minimal access to the children in these institutions.

The shock of transition from infant home to village is experienced on a variety of levels. For instance, the physical appearance and attributes of institutions are glaring signs of the difference between growing up in an institution as opposed to a village. The shock, however, extends beyond physical surroundings to the experiences, which change drastically – literally overnight. A description of Open Arms and the lifestyle of its orphans is provided below and is equally true for Kondanani and SOS,

both of which are similarly distanced from the realities of rural life – even from the surrounding urban communities.

The actual premises of Open Arms are relatively small, though adequate for the number of infants currently housed there. OA owns some of the surrounding land, which is used for growing vegetables (both to supply the home and for sale), and for keeping chickens for their eggs, but this is not immediately obvious as forming part of the infant home itself. There is a house where the two managers live, several outbuildings where guards and ground staff live, and a single building where the children are housed. This last comprises an office, a kitchen, bathrooms, communal play and eating areas, and four rooms where the children sleep. Infants sleep in wicker baskets covered by mosquito netting. Some are in the communal play area, others in the hall and in one of the four rooms. The older children sleep in cots in the other three rooms, grouped according to their age. The atmosphere is quite cheerful, with brightly painted murals on the walls and toys strewn all over the play area and the balcony. In the garden there is a recently constructed 'typical village hut', in which the children play with the understanding that this will make their transition back to their home villages somewhat easier. Of course, for most of the day they remain in their cool, brick building, eating meals in high chairs set on linoleum covered floors and playing with Fisher Price toys donated by people in the UK.

Orphans at OA eat three meals a day at regular times and have a snack both morning and afternoon. There is never any question of a child going without, or having to negotiate/fight with siblings for its own share of food. It is impossible to quantify, or even imagine, the shock that these children will undergo upon return to their rural homes where food shortages are a routine occurrence and, often, the available food is of poor nutritional quality. I observed, too, that it is also crucial for young children to have an older sibling looking out for them to ensure that they receive their share of food. The particular sibling bond, mentioned previously, not only provides a child with a loving person to look after their emotional needs, but it also ensures that someone is looking after their physical needs This may mean sharing their food. The selfless and adoring attention that older siblings give to their 'special' brother or

sister may also extend to a sacrifice of food. When I brought food with me to interviews, I routinely noted that older siblings made sure that their younger 'twin' (such relationships are sometimes described as being as close as twins) had something to eat before helping themselves. This relationship, therefore, is crucial not only for the emotional security that it gives to children, but also for the physical (e.g. protection from bullying, help with strenuous household chores) and nutritional benefits.

A child being separated from its family, and hence its siblings, for the first two years of life may have serious repercussions on this sibling bond and, hence, on the very survival of the orphaned child. Without a caring protector, one surmises that life for an orphan would be extremely difficult and painful. Once OA's follow-up programme is fully operational it may be possible to assess the impact of such early alienation. I managed to visit only one family after a child had returned to them from OA. This situation illustrated that a sibling bond can be created despite there being no contact between the children in the first two years, and that it can be very powerful despite the delay. Benjamin, pictured here with his protective older brother, spent most of our visit cowered behind his brother, who would occasionally pick him up and hold him in my direction, laughing at his brother's frightened cries, but then bringing him in close to comfort him. For the duration of the visit, the protective nature of this relationship was obvious, despite the brother's amusement at Benjamin's tears! This suggests that children who are deprived of such bonds while in an institution and surrounded by children of very similar ages are still capable of being reintegrated into their families,

and of developing this all-important bond with a sibling. Without further examples, however, it is impossible to judge the accuracy of this one example.

In general, relatives do try to maintain contact with their children in infant homes. For financial reasons, though, this is not always possible. One set of twins[17] who were at Open Arms when I first arrived, Paulina and Lewis, regularly received visits from their grandmother who also assumed the responsibility for their care when they were old enough to leave OA. Another set of twins there at the same time, Ben and Febe, also received occasional visits from family. Unfortunately, though, HIV-positive Febe died after only a month at OA, so Ben will be the only child returning to his grandmother.

There is evidence in North America and Europe, where it has been extensively researched, to suggest that the extended family plays a significant role in the emotional and physical wellbeing of a child (e.g. Children and Family Justice Center, 1995; Committee on Early Childhood and Adoption and Dependent Care, 2000). If this is true within a context that no longer practices traditional extended-family living, how much more so is it true in a culture that not only values such support, but which actively encourages it?

Another discrepancy between institutional life and village life is that of health care. Health care for the children in OA is provided through the nearby Seventh Day Adventists Hospital, and constitutes a major expenditure for the home. Kondanani and SOS both have their own purpose-built clinics. Many of the resident children at OA are sickly, premature, malnourished, and/or HIV positive. On my first visit to the home I fed a newly arrived baby, Memory, who was only slightly larger than my hand. Many other tiny infants arrive there in very poor health. Unfortunately, this results in a relatively high mortality rate at the home. For example, thirty infants died in 2001, and it was rare for me to visit without hearing of at least one death that had

[17] The incidence of twins is twice as high in Malawi as in Europe, and there are always several pairs of twins in residence at any one time in Open Arms and Kondanani. Since twins present even more expenses than an orphaned single child, their marked presence in infant homes is not surprising.

occurred in the period between visits. The high death rates in OA, combined with the sudden disappearance of older children once they are two years old, could possibly be highly disturbing to the children that remain.

The extreme vulnerability of many of the children who arrive at Open Arms is a key factor in the mortality rate. There are also, however, amazing success stories; infants who are dying from malnutrition or abandonment are turned into healthy toddlers. One such success story, published on the Open Arms internet site[18], is that of Mphatso, a rare child in that he was formally adopted.

> On the 1st August 2001 a frightened and dirty little boy, whose age we could only guess at was delivered to us by the police. Mphatso (Gift) had been found abandoned in a ditch on the outskirts of Blantyre. Over the last year or two we have seen a rise in abandoned children due, we suspect to the ever worsening socio-economic situation in Malawi.
>
> From the ditch he was taken to Queen Elizabeth Hospital and from there to us. He had a serious scabies problem and would cry at the approach of even the most friendly face.
>
> Over the next six months Mphatso was rehabilitated and became the firm favourite of many but particularly Neville. Because of his lack of any known family he was put up for adoption by the Social Welfare department in Blantyre.
>
> Mr and Mrs Nkhope were a childless Malawian couple living in Bangwe, one of Blantyre's less salubrious suburbs. He had been a manual worker at the Carlsberg factory for 30 years and had saved hard for the day that he and Mrs Nkhope would be able to adopt a family of their own. Mphatso has been with them now since March 2002. He is the apple of his dad's eye and is brought back occasionally to visit us. We visit him once a month on our outreach programme. We are glad to say that he has forgotten us and we look forward to monitoring his future progress.
>
> Footnote: Adoption is a fairly alien concept in Malawi as children who had lost either or both their parents used to be picked up by the extended family system. Since the HIV/ AIDS pandemic this system has broken down to a large degree.

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[18] http://www.openarmsmalawi.org/html/mphatso.htm

This illustrates the positive role that infant homes play in ensuring that children who would not otherwise do so receive the necessary health care, and enabling the survival of vulnerable children. That such provision of health care ceases with a child's return to their village, adds unknowingly to the shock experienced. It further highlights the dislocation between institutional and village lives.

Delex Mandikisi had placed his son, Norman, in Open Arms almost a year before I met him. When discussing his decision and the eventual return of his child, he acknowledged the difficulties Norman would face upon return to village life.

> Question: ...do you think Norman will adapt to living with you?
> *Delex: No, because he will experience some changes as he's having enough food there unlike here.*
> Question: Why did you choose to put Norman into Open Arms?
> *Delex: Norman was very young and I did not have money to be buying milk for him.*

The re-integration of a child into their home community after two years at an institution is a change that has proven to be difficult. Open Arms acknowledges this and fears a high mortality rate among these children once they return to live with their relatives. Until recently, however, there was no system for following up on any of the children who had been returned. When I arrived in Malawi, one of the managers, Neville, was in the process of seeking funding for transportation and staff costs to visit returned children on a regular basis. Such follow-up will be difficult since the children are spread out over a large geographic area, often in locations with poor or seasonal-only access. While waiting for the funding, OA has organized some volunteers to build a traditional style African hut in the garden. Children play there during the day and, ideally, they stay with their relatives in the hut for a brief transition period of a few nights before returning to the village. Once the follow-up system is in place, their progress and wellbeing at home will also be monitored by OA staff, thereby extending the impact of external assistance.

Kondanani is also confronting the problem of reintegration into village life. Due to the increasing number of children who aren't returned to their families, Kondanani has started construction on a Children's Village that will host children from the ages of three to six years, in order to prolong their involvement with the children. The proposed village is described as follows:

> The village will consist of 10-12 houses, each housing 10 children, a 'Host Mother' and a nanny. Each house will simulate a family unit with sleeping, eating and washing facilities. The village will have its own clinic, offices and communal areas. A school will be built for 200 children, half of which will be orphans from nearby villages.[19]

Some children were moved into the village at the end of 2002, but it is still not fully operational and cannot house all the children who remain in institutional care.

The issue of follow-on care is perhaps the key concern of infant homes (though funding is also always a problem). The worry is becoming more acute as the HIV/AIDS epidemic takes its toll on Malawian families and communities. There is an increasing risk, too, that extended families will be unable to accept this responsibility as other OVCs are incorporated into their families. The child who has not been seen in the past two years is easier to dismiss than are those who are present in the village, demanding care on a daily basis. The demand, for follow-on institutions that will accept children from infant homes and raise them outwith the community, is increasing. Orphanages and Children's Villages are the two main responses to this issue (adoption is a very rare third option).

Phiri and Webb point out that 'externally imposed 'solutions' take on a more welfare character' (2002: 14) than do locally developed responses. They add that these external solutions suffer from a general lack of guidelines and standards of care (ibid.), recognizable in the large number of countries around the world that are having to deal with the problem of caring for an increasing number of OVCs. Many

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[19] http://www.kondanani.com/Pages/Kond_Villiage.htm

governments are not taking responsibility for setting these directives and, without coherent and consistent regulations, there is no way to enforce minimum standards of care throughout the many institutions which are being established with the donor money available for projects aimed at caring for OVCs. The opportunistic nature of some of these projects is worrying, and it is highly likely that this problem will increase concomitant with the increasing number of OVCs.

There is a basic misunderstanding regarding the role of orphanages within Malawi, a confusion that is present also in other nations. Phiri and Webb (2002) highlight the fact that members of impoverished, rural communities see these institutions as an opportunity for their children to be fed, clothed and schooled at someone else's expense. Accounts of parents 'temporarily' placing a child in an orphanages in Romania during times of economic hardship, and then returning to collect the child once they are in a better economic position only to discover that they have lost their rights to the child (Michael Harken, personal communication), are echoed somewhat in Malawi. When questioning people about their knowledge and understanding of orphanages, I was told by an elderly woman that '*they are a good thing. Useful.*' When I asked her to expand on this, she told me that orphanages '*civilize*' the children they look after: 'children must speak English and live like the *azungu*'. She went on to state that they provide better care, nutrition and schooling than would the children's own families. This attitude potentially contributes to the number of children from infant homes who face a transition to another institution rather than a return to their home communities.

Transitions are not, however, limited to institutions. Within a village, when a mother dies and her orphans are incorporated into an aunt's or grandmother's household, these children face a transition to an alternate caregiver. This is, however, more of an emotional transition than a physical, and it may occur gradually if the mother's death is preceded by a period of illness. Geographically, female relatives generally live close to each other, with sisters often sharing a communal space between their households, particularly those who have a close sibling bond. The separation of families into distinct households is not very strict: children from combined

households eat communal meals; and older children may move in with another relative when assistance is required. Both agricultural and household tasks are shared between households. In general, children have extremely close emotional relationships with their aunts, uncles and grandparents. Female children, for instance, discuss emotions, sexual issues and general gossip with an aunt or grandmother, rather than their mother, while boys do so with their maternal uncles or grandfather. There is, therefore, a significant amount of contact between the child and the future caregiver even before this relationship comes into being. The physical movement of a child from one household to another occurs uneventfully, often before the actual death of a mother, so that children are used to their new living arrangements by the time their mother dies. Even in cases of sudden death, the preceding relationship with the caregiver's household makes this transition relatively straightforward. Transitions within the family are, therefore, the least stressful to orphans, though obviously the association with maternal death obviates the possibility of any stress-*free* transition.

In these instances, it is the emotional transition that is the most significant. Orphans face the loss not only of their mother, but also (in the case of girls) the loss of a close relationship with their aunt. Once the aunt or grandmother becomes the primary caregiver, in effect the 'mother', the relationship must be redefined to take this necessity of respect into account. The very adult who would normally be expected to help the young girl through the difficult adjustment to her mother's death, is 'withdrawn'.

Newly emerging households

Despite the presence of various institutions aimed at alleviating a community's burden of OVCs, the extended family remains the primary source of aid for orphans. A key consequence of this reliance on kin networks is the changing nature of households and residence patterns. Barnett and Whiteside enumerate the many ways in which household composition has changed in South Africa subsequent to high AIDS-related mortality and the associated increased number of OVCs:

> New forms of household are developing as a response to the impact of HIV/AIDS. Some of the more unique responses include elderly household heads with young children, grandparent headed households; large households with unrelated fostered or orphaned children attached; child headed households; cluster foster care – where a group of children is cared for formally or informally by neighbouring adult households. Unfortunately where care is not available children are increasingly itinerant, displaced or homeless often in groups or gangs or found in subservient, exploited or abusive fostering relationships. (2002: 14)

Similar changes are occurring within Malawi, though cursory observations suggest that Malawi has fewer alternative kinship arrangements than surrounding countries, due primarily to the fact that traditional kin structures remain largely intact. However, increasing pressure is jeopardizing the current care mechanisms for OVCs. Barnett and Whiteside point out that it is estimated that orphans will constitute 30% of Malawi's population by the year 2005, and that this figure will increase to 35% by the year 2010 (ibid. 19). Yet, 'the situation in Malawi...may be better' than in surrounding countries (ibid. 20). There are no reliable figures relating to the number of child-headed households in Malawi (or, for that matter, in most of sub-Saharan Africa). The most extensive data collection on orphan statistics was carried out jointly by USAID, UNICEF and UNAIDS and is presented in their annual *Children on the Brink 2000* publication (Hunter and Williamson, 2000). This document has meticulous statistics for the number of orphans in selected countries in sub-Saharan Africa but no indication of the number of child-headed households. The authors restrict themselves to commenting that:

> The impact of HIV/AIDS on the family structure has not been widely studied, but extensive anecdotal evidence suggests that children are increasingly living in various types of families, including households headed by single parents, grandparents, other relatives, and children themselves....These alternate forms of families are constantly evolving, and psychosocial distress affects their ability to cope. (2000: 10)

There is obviously too little data on the full scope of the 'orphan crisis'. Those publications that deal with the topic often do so in categories of orphans – restricted by age, whether they have lost a mother, father or both parents, and the cause of

death of the parent(s). The problem is so immense as to be impossible to comprehend and analyze in its entirety. What is clear, however, is that kin networks constitute the primary source of aid for OVCs, and that this assistance takes a variety of forms. Within the areas studied for this research, there were households where the main carer was an elderly grandparent, and other instances of sibling carers. In these latter instances most of the heads of household I met with were in their late teens or early twenties and, therefore, outside of the categories of 'child' or 'adolescent' headed households. As the following case study points out, though, this was not always the case:

> Ignazio is twenty-four-years old and is looking after his four brothers and one niece at his own insistence (though his decision to take on such responsibility was based on the fact that his other relatives were too poor with too many of their own obligations to take in any more orphans). His mother died in 1997, and he has been responsible for the wellbeing of his siblings since then, making this a household which, for some period, was headed by an adolescent. His youngest brother, who was aged four at the time of their mother's death, went to live with an aunt. His twin sister died in 2000, leaving him in charge of her daughter. His mother had been village chief and the villagers, therefore, gave him a lot of help with the funeral costs. Thereafter, however, he received no further assistance. He attributes his success in caring for his brothers and niece to help received from his parent's spirits: *'I believe in our parents' spirits as our tradition portrays. These spirits help me because I couldn't (manage) with my brothers (otherwise), but after I prayed to the spirits, my situation changed.*' His parents have blessed his farming, allowing him to produce enough to support his family. Other than the fact that his aunt is caring for one of his brothers, he has received no material help from his relatives. He does, however, spend a lot of time at his aunt's house. His children and his aunt's three children sleep at each others houses interchangeably. The two households occasionally eat meals together and his youngest sibling spends a lot of time at the aunt's house, since she has

children of a similar age and he is '*very young...he was only interest(ed) to be sleeping with their friends.*'

Ignazio is doing as good a job of providing for the children in his care as others in the village, but the responsibility is draining. When I asked him about his plans for marriage and a family of his own he replied, '*I don't want to have that responsibility because I may end up looking after many children as I have witnessed from the six I am looking after. I don't think of marrying either.*' The emotional toll of his caregiving responsibilities is obvious, and the fact that he still classifies himself as an 'orphan' himself indicates in some way that he is not emotionally prepared for this difficult role that he has taken upon himself.

As highlighted in a previous chapter on kinship, definitions of orphans are highly variable. Barnett and Whiteside state that 'there is no final way of deciding who is or is not an orphan, it is a social role and varies from place to place and culture to culture and impoverishment goes beyond the mere fact of being orphaned' (2002: 15-16). That Ignazio and others his age, or even older, still defined themselves as orphans reflected the fact that they were unmarried and, therefore, not wholly adult in the eyes of the community, i.e. socially still children. The link between orphanhood and being classified as a child could be as much an acknowledgement of the emotional toll of losing a parent as being social definitions of adulthood and childhood.

Orphan-headed households may be a relatively stable feature or a provisional response to a death. Foster *et al.* (1997*a*: 158) highlight the fact that household formations subsequent to a mother's death may be temporary, thus increasing the difficulty in assessing the number of houses that are headed by children, adolescents, immediate kin or near kin. The shifting composition of households may mean that a single physical household unit may at times be classified as adolescent-headed and then, when that adolescent head leaves to seek employment, child-headed. Finally, a

relative may step in to provide assistance (on a temporary or permanent basis), thus re-classifying the household again.

> Families take time to organize coping strategies in response to unaccompanied children.... The appearance of child-headed households does not necessarily mean that extended families are abandoning their responsibility to care for relations' children. This study demonstrates that among households with known relatives, most were receiving regular supportive visits and small amounts of material support from their extended family. (Foster *et al.*, 1997*a*: 166)

In the same article Foster *et al.* also point out that:

> The new phenomenon of child-headed households appearing in communities affected by AIDS is an indication of saturation of traditional extended-family orphan coping mechanisms. Some communities may have better preservation of traditional coping mechanisms, such as those in remote rural areas with little urban migration and with lower life expectancy; the more traditional the community, the more capable it may be to cope with increasing numbers of orphans. (1997*a*: 165)

An example of such a community, which has succeeded to some degree in using traditional coping mechanisms to address increased numbers of OVCs, is Songani. Its success has not come easily, however, particularly given the scope of the problem: most families in Songani are looking after at least one orphan, either directly or indirectly, an indication of the extent of the crisis. The implementation of SOCCG has been a significant boost to those families that are involved. Access to SOCCG resources, however, is on a first-come-first-served basis and thus it does not necessarily target those families who are most needy. Currently, the organization does not have the capacity to increase the number of families for which it is providing support. It is taking on new families only when a current member no longer has orphans to care for (because of the orphan moving to another relative, growing up to the point of independence, or dying). There are more families wanting to participate in the scheme than there is capacity and, as the following excerpt from my fieldnotes (22 November 2001) illustrates, people have high expectations of the benefits of belonging to SOCCG:

Gladys' poverty, and her struggles to cope with the demands of caring for orphans, are typical of the majority of caregivers in the SOCCG beneficiary group. She is a grandmother caring for three children. One of the children is her own, and though an adult, is extensively mentally retarded and, therefore, incapable of caring for herself. Gladys' second daughter maintains her own household. Whenever possible, though, she provides limited assistance to her mother. Gladys is looking after two children from her third daughter, who died in 2000. Though she doesn't know exactly how old she is, Gladys is very elderly She told me that farming was becoming increasingly difficult, not only because she is weaker as she gets older, but also because of hunger. At the Christmas distribution she did not even have the strength to come to the community centre to get her family's allotment of maize, goat meat, clothes and soap, and I dropped it off at her house on my way home. Both of the orphans in her care appear malnourished, and are poorly dressed, even more so than their neighbours. An aunt of these children told me that the eldest, a boy of 12, is '*very, very naughty*'. Apparently he '*steals food from everyone*' and has been reprimanded by the village chief for his bad behaviour. As a relatively new member of SOCCG, having joined in mid-2001, Gladys has already received a new roof for her house from the group, and is hopeful that with SOCCG's assistance her situation will improve, and that of the children in her care.

Conclusion: The realistic solution

The majority of rural Malawians do not understand there to be options with regard to orphan care other than incorporation into the extended family. This chapter has outlined some of the alternate care arrangements that are ostensibly available, but it must be reiterated that these are accessible only to a small minority of the population. Even were institutional care arrangements to be more widely available, they do not constitute a realistic solution to the problem. Nor is it possible to stand back and do nothing, since failure to provide support for existing traditional coping mechanisms will surely result in their destruction. Interventions, therefore, must be aimed at

supporting the remaining kinship structures, and reinforcing those community initiatives that have already attempted to address the needs of orphans and their families.

The profound impact of maternal deaths and the associated OVC crisis on communities has been felt throughout every aspect of life in Malawi. Yet, despite the clarity of this crisis, and despite a verbal commitment on the part of international donors to fund community projects aimed at addressing these issues, interventions have failed to learn from the successes of groups such as SOCCG. The next chapter discusses the role of development organizations and the Malawian government in supporting programmes that aim to reduce the burden of OVCs on families. It elaborates further on why the funding for community groups has not been effectively implemented, and recommends ways in which this predicament could be addressed.

CHAPTER 7: ORPHAN CARE AND DEVELOPMENT

Numerous examples of the impact a mother's death has on her family and community have been presented in preceding chapters. This chapter now builds on these to portray the impact that such deaths have at a national level. By examining the role of government and development organizations in providing support for communities affected by high levels of maternal deaths and increasing numbers of OVCs, the following discussion highlights the severity of the cumulative impact of such problems. Key to this discussion is the portrayal of government agencies and development organizations as being out of their depths, without the capacity (in some instances, the willingness) to support the initiatives that will best serve to address the needs of OVCs. By positioning the ramifications of maternal deaths within a national (even regional) framework, the severity of the issue is emphasized.

Implications of current orphan-care methods for both communities and the government are considered here. The discussion draws on previous descriptions of the implementation of such care at community and institutional levels to highlight the interaction between development work and local communities and the feedback that influences development initiatives. An example of this interaction is the expansion of the definition of orphans (provided in Chapter 3), to place emphasis on the role of aid organizations in creating the category of orphans, and thus positioning themselves to provide 'the' solution to the problem. Aid projects affect local communities in terms of knowledge, attitudes and practices. The role of external development experts in the arena of orphan care is examined using the concept of authoritative knowledge (AK) to elucidate the way in which certain practices have become official policy. Furthermore, this process is compared with that of colonialism, particularly as expressed through health and development projects in modern times. The responsibilities of development organizations and the Malawian

government are explored within the framework of neo-liberal globalization and debates on governance.

A critical appraisal of the issue of 'sustainability' within the context of orphan-care projects questions the ethics and suitability of this as a goal of development projects. The chapter then segues into a discussion of education, introducing a key aspect of society that is compromised by the growing number of OVCs. Suggestions relating to the education of orphans (both through formal education and socio-cultural methods) are integral to the recommendations for project implementation at the local level that conclude this chapter. Some guidelines for the establishment of a participatory project aimed at assisting communities in their efforts to care for OVCs are also presented.

The 'development' of a new category of 'orphans and vulnerable children'

As mentioned previously, the specific categorization of certain children as 'orphans' is a relatively new phenomenon among traditional, rural communities in Malawi, and indeed in Africa (personal observations in line with Foster, 2000; Foster, 2002). Definitions of kin are linked with the responsibilities of providing care and support to individuals as necessary: the assumption of a caregiving role to a child orphaned by a kin member is done without question, and even without planning.

This lack of apparent forethought in assuming the role of caregiver was one of the most difficult aspects of Malawian culture for this researcher to understand and interpret. At first, I was surprised that Malawians within my research group did not articulate plans for dealing with orphans within their family, or for their own potential survivors. With only one exception, this was true also for those who were HIV positive. Through both formal and informal questioning, I could not get any explanations of the *process* whereby orphans are assimilated into a particular family. There were apparently no hand-over procedures followed to transfer responsibility from one member of a family to another. Even the change in residence location, which usually occurred for orphaned children, seemed to happen on an *ad hoc* basis: for instance, children would be moved at greatly different times ranging from several

months prior to their mother's death to several months *after* the mother's death. There are no rules or guidelines for this transference, rather it occurs as a response to the needs of a child who has suddenly become an orphan.

After a while, it became clear to me that the reason for there being no forethought involved on the part of a woman who is dying and leaving children, is simply that there is no need for such planning. It is understood at an unconscious level that family members will care for the child and, often, the mother knows the identity of the future caregiver[20]. This is usually the other half of the mother's 'sibling pair', the two of whom reside within close proximity and will have extensively merged households. Usually, grandmothers are only called upon as caregivers if none of the mother's siblings is capable of doing so. Sometimes grandmothers provide living quarters for the orphans while siblings of the deceased provide financial support. It was reiterated to me during countless conversations, however, that this agreement was seldom verbalized. The current caregivers assured me that prior to a mother's death there had been no conversations wherein arrangements were made for the care of her children. Execution of care duties progressed naturally from the existing kinship bond. Often, too, children were under the care of an aunt or grandmother prior to the death of their mother, because the mother was too ill to take responsibility herself; the arrangement simply became more permanent upon the actual death. In such cases, objections and problems with the situation could be worked out while the mother was alive, so that she could die knowing that her children were in good hands and in a pre-established relationship. Even in those instances where the mother was not ill prior to her death, and no gradual handover of her care-giving role occurred, the female relatives generally are near neighbours and provide assistance to each other in many various ways, including sharing the

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[20] Caregivers assured me that even though they hadn't discussed the current arrangement with their deceased sister/daughter, she knew what would happen to her children and where they would be, even without articulating such eventualities. Those women who were HIV positive and knew they were going to die also told me that there was no need for them to confirm child-care arrangements with their mothers, since their mothers would automatically take over their role as prime caregiver to the orphaned children.

responsibilities of childcare. Children, therefore, already have experience of being looked after by their female relatives, which may ease the transition subsequent to being orphaned.

The lack of planning typically associated with orphan care arrangements is, however, increasingly becoming a thing of the past. There are indications that more forethought is accompanying the role of parent now that HIV/AIDS has increased the death toll to such a great extent. Research in Zambia (Baylies, 2000) has suggested that family size preference may be influenced by the assumption that sooner or later a household will be required to incorporate orphans. There is some pressure, therefore, on couples to limit the number of their own offspring, in order to save resources for the eventuality of accepting orphans from other kin, and to limit the number of orphans that they would leave on their own death. One of my informants, an orphan named Ignazio, told me that this was a consideration in his decision not to have children: '*I don't want to have that responsibility because I may end up looking after many children as I have witnessed from the six I am looking after. I don't think of marrying either.*' Furthermore, there are a growing number of anecdotes to suggest that extended kin may now not be so complacent in accepting the roles and responsibilities handed down to them through traditional customs. Child- and adolescent-headed households are evidence of such a change in values. As the impact of HIV/AIDS is felt more acutely by individuals, families and communities, the unquestioning absorption of orphans into existing kinship structures is being undermined and, therefore, it is less likely that a dying woman can be secure in the belief that her family will assume responsibility for her children.

The saying, popularized by Hilary Clinton, that 'it takes a village to raise a child' echoes the premise that Africa had no orphans. Those who would be classified as such in western society were incorporated so rapidly and completely into their extended kin group that they were not isolated, categorized or labelled in any way that would distinguish them from other children in their village. This lack of distinction, however, is no longer certain. Part of the blame for this must be laid at the door of the international aid community. The thread of recent discussions on the

Children Affected by AIDS (CABA) on-line forum, highlights the problems associated with identifying particular categories of children as 'CABA'. People working with these children have recently started reporting that the children themselves object to this labelling, viewing it as dehumanising. One contributor to the listserv cites the following anecdote:

> ...during some recent work in Zimbabwe, I was very concerned to hear people at community level identifying particular children as 'our CABA.' They were simply using terms that they had heard agency staff using. When one of my colleagues met with a group of children, they told him, 'We are children. We don't want to be called 'CABA.'' Acronyms can be handy shortcuts in our work, but they can also become stigmatizing labels that do harm. I suggest that we take the time to say and write what we mean and try to avoid labelling. Where such terms are already being used at community level, it is a good idea to engage adults and children in discussions about how they feel about their use. Often community residents use such jargon because they believe it what the people with the money want to hear. (CABA, 2003[21])

This recognition of the negative impact of an aspect of development project implementation on local cultures is not new, and is not limited to the category of the children discussed in this thesis – variously called AIDS orphans, orphans and vulnerable children, or children affected by AIDS. The labelling and categorization of aid recipients has been a matter of discussion and critique for the past few decades. In his book *Rural Development: Putting the Last First*, Robert Chambers (1983) discussed how external development 'experts' failed to include local communities in development plans. He highlighted the fact that this led to developments that were unacceptable to the local community and, therefore, failed. Caroline Moser (1993) built on the critique of development practices in her book *Gender Planning and Development: Theory, Practice and Training*. She pointed out that, once development experts began to consult members of the local community, they inevitably focused on the male members, thus creating projects which did not necessarily meet the needs of the most impoverished and disadvantaged community members, namely women and children. While the subsequent focus on women in

[21] http://list.s-3.com/cgi-bin/wa.exe?A2=ind0306&L=caba&F=&S=&P=1371

development led to many positive changes in the international aid apparatus, and has been linked to aspects of female empowerment among under-privileged communities, it has also created resentment among some male members who feel that women receive preferential treatment (Diallo *et al.*, 1998; Hein, 1998).

There are indications (e.g. UNAIDS/UNICEF, 1999; Guest, 2001) that a focus on AIDS orphans alone has created resentment among other members of the community, particularly among the peer group of the orphans: hence, the current focus on terms such as 'orphans and vulnerable children (OVCs)' and 'children affected by AIDS (CABA)'. These terms not only broaden the category of children eligible for assistance, but also heighten awareness of the far-reaching implications of the HIV/AIDS epidemic. As discussed in Chapter 3, definitions of orphans serve as a way of defining the scope of the ramifications of HIV/AIDS. Yet the impact of this pandemic is far more profound than simply an increase in the number of children who have lost a parent, or parents, to the disease. Estimates of the number of children affected by the HIV/AIDS epidemic are possibly hopelessly under-representative of the true scale of the disaster.

In a paper for the Association François-Xavier Bagnoud, Neil Monk discusses the techniques used for enumerating children orphaned by AIDS, and the policy implications of the various totals presented by different agencies. UNAIDS, commonly used as the authoritative source of statistics regarding the impact of HIV/AIDS on countries and communities, estimates that by the year 2010 there will be 26.4 million AIDS orphans worldwide. USAID has expanded this estimate to include paternal orphans in certain countries, increasing the number by up to 45%. Monk maintains that both figures are gross underestimates of the true number, which he places at 100 million by the year 2010. He cites several reasons for this discrepancy in global totals. Firstly, UNAIDS' and USAID's categories of orphans are limited by age, an artificial limit since 'orphanhood can often serve to extend the period of dependency for a child. This is caused by the emotional and financial strain of parent loss and, especially, delays in schooling during the initial period of orphanhood' (2002: 9). It must be noted that cultural definitions of 'children' vary

greatly and, in Malawi, marriage and parenthood are intrinsically linked to becoming an adult. Until these states have been accomplished, therefore, one is often categorized as a child regardless of age. This is true of many other societies, too, reinforcing the fact that limiting the category of orphans to those under a certain biological age does not necessarily reflect their social reality. As Phiri and Webb state:

> Frequently, the community's own definition of vulnerability also includes children who are not defined as orphans in the western sense, such as disabled or destitute children who may not necessarily be biological orphans but may be termed as social orphans. In fact, children start suffering economically, psychologically and in other ways long before they become orphans. This mismatch between community's notions of vulnerability and the imposition of external definitions tends to result in a topdown approach that is unlikely to encourage community 'ownership' of programme activities. In addition, the focus on the stigmatising term 'AIDS Orphans' creates a situation where other vulnerable children may be left out of assistance activities. Communities know the children about whom they are most concerned, as in Malawi; '...in other communities, however, orphans appeared to be a primary focus because their needs have been emphasized by external bodies. Some communities were coming to see orphans as a privileged group and resented this displacement because it undermined extended family mechanisms.' (Williamson and Donahue, 2001) (2002: 8-9)

A note of caution may be sounded with regard to the labelling of certain children as vulnerable. Do communities respond to the fact that outsiders are looking for such children by creating them – consciously or unconsciously? Possibly, this was an issue of concern when vulnerable children were few in number, and before the full scope of the impact of the HIV/AIDS pandemic was understood. Faced with the realities of high death tolls and the breakdown of traditional kin and community coping mechanisms, however, it is clear that this categorization is only hastening the acknowledgment of a group of children who, by and large, did not exist until recently.

Based on his own research in Uganda and India, Monk's second reason for the discrepancies in global figures is that the reported numbers of paternal orphans are

more than likely underestimates. Thirdly, the category of non-AIDS orphans is excluded from both estimates. As highlighted throughout this thesis, it is not only those children whose parents die of AIDS who are directly affected by the death. Instead, the impact of these deaths is felt throughout the extended family and community, and up to the national level. Fourthly, 'de facto orphans' are completely excluded from official estimates. These are children who, 'although not orphans within the widest possible definition, (are) still subject to the same experience as orphans.' (ibid.: 15). Most commonly these are children who, because their parents are terminally ill, are being fostered by other family members, possibly along with actual orphans or other children in the same situation.

> Just as the distinction between 'AIDS orphans' and 'non-AIDS' orphans can disguise the impact of the HIV/AIDS pandemic on orphans, then a distinction between 'orphan' and 'non-orphan' children in the same household disregards the true impact of the orphan crisis, as many non-orphans are equally affected (ibid.).

Finally, Monk points out that the UNAIDS estimates exclude the populations of India, Somalia and eastern Europe, while countries that are just beginning to acknowledge the HIV/AIDS epidemic, such as China, are underrepresented. Since these countries have huge populations, the prediction of 100 million orphaned children is not unrealistic.

Phiri and Webb go beyond even Monk's estimates, citing their study in Uganda which yielded a total number of AIDS-affected children (maternal, paternal and double orphans under the age of 18, plus co-residents also under the age of 18) nine times higher than the UNAIDS estimate for the region. 'If other research yielded similar findings this would give rise to even more alarming estimates and projections than those produced by UNAIDS, i.e. 218.7 million by 2010 and 360 million by 2020.' (2002: 6)

One further use of the term 'orphan' is worth mentioning here, and that is the emergence of the category of 'elderly orphaned' (Guest, 2001). This refers to the generation of grandparents who are raising their grandchildren, having lost their

children to AIDS-related deaths. Children are expected to care for their elderly parents, in effect to serve as 'pensions' and 'social security'. By pre-deceasing their parents, they leave orphaned grandparents who now have not only lost their security, but have become further impoverished by having to share limited resources with another generation. Also, their working lives are extended beyond previous expectations.

The classification of orphans, and their subsequent enumeration, has obvious policy implications. Development initiatives would focus on a very narrow group of beneficiaries were they to adhere strictly to UNAIDS definitions of AIDS orphans. This would limit their impact in communities and, possibly, create resentment among other children over the special attention paid to such a small subset of the vulnerable. Monk argues that the 'under-reporting of the AIDS orphaning pandemic may be one reason that this crisis has failed to grab the attention that is required for adequate resources to be mobilized in support of the children affected.' (2002: 3). Another policy implication results from defining orphans as a 'problem'. Agencies position themselves as being able to supply the solution, thereby furthering their involvement and enabling them to continue to provide employment to their staff. While this is not necessarily a prime motivation in tackling the issues which arise with orphaned children, it cannot be denied that, to some extent, the development industry does not wish to promote sustainable solutions and capacity-building to the extent that individuals from these agencies are no longer required for lucrative consultancies.

Lessons learned from past experiences of development projects include the caution against focusing on one particular group to the exclusion of others. It is mainly for this reason that terms such as 'OVCs' and 'CABAs' are gaining in popularity. This focus on a larger group of children, together with an emphasis on the wider implications of the HIV/AIDS pandemic, will hopefully promote more-integrated development responses. It is clear that, more so than ever, these development initiatives must take their cue from grassroots activities and build on existing community efforts. Interventions to deal with OVCs can either hasten the undermining of the traditional kinship structure and community coping mechanisms,

or support them and enable their survival through a period of unprecedented stress.

The next section discusses the concept of AK, a significant barrier to the latter choice.

Authoritative knowledge and development initiatives

Brigitte Jordan, who articulated the concept of AK, relates the idea of AK as follows:

> The central observation is that for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both.
>
> In many situations, equally legitimate parallel knowledge systems exist and people move easily between them, using them sequentially or in parallel fashion for particular purposes. But frequently, one kind of knowledge gains ascendance and legitimacy. A consequence of the legitimation of one kind of knowing as authoritative is the devaluation, often the dismissal, of all other kinds of knowing. (1997:56).

AK has been used to devalue alternate systems of practice, knowing and understanding of the processes of pregnancy and childbirth in the developed world. It has also served to reify the entire system of Western medicine, not only that associated with pregnancy. Insofar as, historically, doctors were male and midwives female, it has also served to devalue women's forms of knowing and promote male hegemony in the medical sciences. Finally, AK is also inextricably linked with the colonial process and the implementation of health programmes in the developing world. Where these programmes are implemented, it is assumed that the Western biomedical means of combating morbidity and mortality are superior to those used by the local populations. Even in instances where local biomedical activities are encouraged, such as in the WHO and UNICEF campaigns to utilize and better train traditional birth assistants (TBAs), it is the outsider, as colonialist and purveyor of Western AK, who decides which practices are beneficial (and therefore to be

encouraged), harmless (so can be maintained in order not to risk appearing culturally insensitive) or harmful (requiring active discouragement).

The idea of Western medicine being linked to the colonial project has been expressed by several theorists, including Butchart in his book *The Anatomy of Power* (1998), and Jean Comaroff in her essay *The Diseased Heart of Africa: Medicine, Colonialism, and the Black Body* (1993). In the latter, Comaroff highlights how the early missionary doctors ministered to the Africans in order to save both body and soul, and how this served to reinforce cultural and racial stereotypes. Western medicine was there to save the continent, '[thus] did the metaphors of healing justify 'humane imperialism', making of it an heroic response rather than an enterprise of political and economic self-interest' (1993: 313). Medical interventions often serve as a primary component of international aid. Thus, as for medicine, there is also an association between development programs and colonialism. Grillo (1985) places development assistance and imperialism on the same continuum, with colonial development schemes mutating into state-led 'modernization', an assertion that owes much to neo-Marxist critiques of capitalist development which does not necessarily translate into improved lives for those being developed. Critiques of development draw on dependency theory and world systems theory (most notably Robert Chambers, who appropriates the oppositions of 'core' and 'periphery' in his critique), highlighting the colonialist nature of modern development.

There is still some association between development and colonialist attitudes and ideas, primarily at a global level, and reified within the International Financing Institutes (IFIs) such as the World Bank (WB) and the International Monetary Fund (IMF). Their neo-liberal economic policies, exemplified by the Structural Adjustment Programmes (SAPs) imposed on developing nations, have served to further impoverish these countries while reinforcing western style AK with regard to a wide range of topics such as health care, agriculture, and governance. There is, however, an indication of a move away from these policies on the part of some NGOs in particular, and even some organizations of the UN. Thus the emphasis on community capacity building and social network support is largely in opposition to

the goals of the IFIs. Yet AK is still a tool of development, which, on occasion, can undermine the efforts of CBOs to tackle problems such as those associated with the increasing number of orphans. Therefore, it also serves to highlight the impact of development initiatives on communities.

Since AK is not defined as knowledge belonging to those in authority, but is rather associated with those who 'know how to manipulate the technology and decode the information it provides' (Davis-Floyd and Sargent, 1996: 8), this demonstrates how rural, largely uneducated people can be excluded from the process of AK creation and manipulation. It should be remembered, however, that insofar as knowing how to manipulate and work within the framework of existing AK concedes authority on an individual, AK reinforces the status and power of those in authority while also serving to perpetuate the AK in a circular manner. Thus, those in positions of power within a given system have ascribed to the AK and have a vested interest in perpetuating its acceptance amongst others. While this is true, then, AK *does* belong to those in authority (as they themselves belong to AK) and can be manipulated by them to best serve their interests. This distinction is important when discussing AK in the context of Africa, since its governments usually subscribe to the beliefs of western AK and actively seek programmes that will establish it in rural areas. The government uses the imposition of AK to create some uniformity of belief amongst its citizens, and AK therefore becomes a tool in the creation of a nation state (another colonial imposition) mimicking European and North American nation states.

Within the context of orphan-care projects, AK is most obviously expressed in institutional care. Thus the SOS Children's Village in Lilongwe has been designed using a concept of what a 'typical' and 'traditional' African village should look like. An ideal based on romanticized notions of Traditional African Society that owes much to the philosophy of, for example, Julius Nyerere and Leopold Senghor. That the community bears little resemblance to the villages surrounding it is obvious to even the most casual of observers. Indeed, it is acknowledged in promotional literature. Despite the staff's insistence, however, that the facility is run in a manner, culturally comparable to neighbouring communities, the distinct lack of men in the

village and particularly of male authority figures, is a glaring contradiction to this, as is the pristine state of the new, brick buildings and tarred roads throughout the compound.

Distressingly, a symptom of the Malawian government's acceptance of the external world as purveyors of AK is expressed in the proliferation of orphan-care projects initiated, owned and operated by expatriates. A fundamental assumption that *azungu* know better than Malawians, translates into increased support for projects which are run by these *azungu* in urban settings, rather than a commitment to support community-based initiatives in rural areas. This is reinforced by many organizations from the international community which, while professing support and even preference for these same CBOs, do not have the mechanisms or willingness to distribute funding to these small-scale ventures over prolonged periods. Their funding of institutional care is taken as support. Thus as Jordan warned, 'the legitimation of one kind of knowing as authoritative is the devaluation, often the dismissal, of all other kinds of knowing.' (1997:56).

'Good governance' and neo-liberal globalization

The concept of 'good governance' is increasingly gaining in popularity amongst the development community. Therefore, in 2000/2001, many organizations and governments withdrew financial support from Malawi in response to revealed government corruption under the rubric of punishing any regime not seen as compliant with principles of good governance.

The World Bank cites concepts such as 'transparency', 'efficiency' and 'accountability' in its discussions of good governance, while the African Development Bank (ADB) states that

> Among the many definitions of 'governance' that exist, the one that appears the most appropriate from the viewpoint of the Bank is 'the manner in which power is exercised in the management of a country's economic and social resources for development.' ... In broad terms, then, governance is about the institutional environment in which

> citizens interact among themselves and with government agencies/officials. (ADB, 1995[22])

Fighting corruption at both the government and project levels is deemed crucial to the success of development initiatives. In fact, one paper published by the World Bank is titled 'Good Governance: The Key to Poverty Reduction and Prosperity in Bangladesh', and opens with the line 'Governance matters, in Bangladesh and elsewhere.' (World Bank, 1999: 1). Yet, perhaps unsurprisingly, given the sources and notwithstanding the ADB's mention of 'social resources', the emphasis is continually placed on financial good governance, with little emphasis on the roles and responsibilities that governments have towards the social development of their citizens. As stated by Dransfield and Leppard,

> ...the imposition of structural adjustment programmes which reduce social sector spending may contradict the requirement of the international financing institutions (IFIs) that states should be accountable to the electorate. (Unpublished paper: 3)

Indeed, the efficiencies required by neo-liberal globalization, and thus by the World Bank, go further than obstructing accountability. They actually prevent governments in developing countries from providing services to meet the basic human rights of their citizens, including the following as stated in the Universal Declaration of Human Rights (1948):

> Article 22: Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.
>
> Article 25: (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in

[22] http://www.adb.org/Documents/Policies/Governance/

circumstances beyond his control.

> Article 26: (1) Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

Increasingly, the services that would support the fulfilment of these rights are being offered and implemented by NGOs rather than governments. In Malawi, one sees that the government is handing over its responsibility to govern to external development organizations, and is failing in its duty to local communities. Where NGOs aren't stepping in to counteract this lack of government services, CBOs are doing so instead. This is made possible largely by the resilience of Malawians who have evolved complex coping mechanisms over centuries in the face of continued economic, physical and social hardships. As Foster points out,

> ...it is somewhat paradoxical that the effectiveness of the traditional African social system in absorbing millions of vulnerable children has contributed to the complacency of governments and agencies in addressing the orphan crisis.' (2002: 1907)

Thus, it is only as cultural coping mechanisms are being overwhelmed that the Malawian government is beginning to comprehend the full impact of the HIV/AIDS disaster, and attempt to respond accordingly.

A prime example of community responsibility for social service provision is that of 'home-based care'. As it becomes increasingly obvious that government hospitals are incapable of providing the long-term palliative care required by those who are HIV-positive or dying of AIDS, the responsibility for doing so has fallen increasingly on family members and community volunteers. Unfortunately, female children bear the brunt of caring for their sick relatives (which often entails their removal from school), thereby further jeopardizing their futures. Without the commitment of home-based care providers (both those who are formally trained for this function and those who simply assume the job in response to an obvious need), the suffering of AIDS

victims[23] would be more obvious to the rest of the world, and result in a heavier burden on government hospitals.

One further point remains to be made with regards to the argument that the government is devolving its responsibilities to the citizens, whether or not they are willing and/or able to accept this extra load. As reiterated throughout this thesis, traditional coping mechanisms are being overwhelmed in the face of unprecedented mortality rates. It can only be a matter of time before they succumb completely, unless innovative mechanisms of support are discovered and implemented. Unfortunately, hand-in-hand with this pressure on traditional coping mechanisms is the emergence of a newly wealthy middle class who do not feel any obligation to support their fellow citizens. Two observations of mine during fieldwork typify this lack of social commitment.

> When visiting Open Arms my usual intention was to remain only for an hour or so (depending on what I intended to do there, and what my plans were for the rest of the day). Seldom was this the case, though, as immediately on arrival I would be surrounded by children, clamouring for attention. Typically I would end up playing with half a dozen or so, while simultaneously feeding an infant and a toddler, and chatting with the nannies. It often happened, therefore, that I was at OA around lunchtime. Rather than have the nannies share their food with me, since they brought it in themselves, I would wander down to a supermarket about a kilometre away. This was in the middle of Blantyre, and had some tables and chairs outside for customers to lunch at. I would sit there, eating a pie and drinking a coke, and watching the people around me. Since eating at a supermarket (as opposed to a market stall) is a luxury few can afford, the people at the other tables were inevitably wealthy

[23] The use of the term 'AIDS victims' is often criticized by AIDS activists, yet is used here to politicize the status of those who are infected. They are 'victims' not only of a disease, but of a government failure to commit to the fight against HIV/AIDS, a global failure to ensure the free supply of anti-retrovirals, and the victims of unequal gender relations in the country. They are victims because they have been denied the opportunity and education to prevent their infection.

Malawians. They would pull up to the kerb and get out of shiny, new Mercedes Benzes, were always smartly dressed and, usually, chatting on mobile phones. Yet, despite their obvious wealth, the street children would never approach them and beg. Instead, they would come directly to me, usually the only white person sitting there.

After lunch I would return to OA, where I would probably meet various volunteers from around Blantyre who would come in to help. Without exception, these were all expatriates, usually women whose husbands were working in Blantyre or children from the local international school, St Andrews. Despite there being a number of Malawian women in Blantyre who are western-style homemakers, they are not involved in community volunteering.

This is not to say, however, that wealthy Malawians are uncaring or ignorant of the plight of those less fortunate. Many of the monied Malawians I knew personally were taking care of family members – either directly by absorbing orphans into their households, or indirectly through financial assistance. They felt under no obligations, though, to society in general. Concepts of volunteerism and personal obligation to society are not developed, and this is in large part due to the fact that one's 'society' or 'community' is generally defined and limited by kinship. Therefore, by meeting family obligations one is absolved of having to feel responsibility for others in society.

Finally, I often heard the criticism that the Malawian government is responsive to disasters in its strategies, rather than proactive with attempts to avert and avoid them. While this is valid, it must be understood within the context of the extreme poverty that defines the government's operational structure. The government works with limited resources. The huge amounts of foreign financial assistance come with many conditions and restrictions. As mentioned previously, these are not always in the best interests of Malawian citizens. Furthermore, one must remember that the government is made up of individuals, many of whom are facing similar constraints to their

productivity as confront the civilians. HIV/AIDS, for example, is taking its toll of ministerial personnel. Even those who are not themselves infected are becoming increasingly responsible for family members who are orphaned or too ill to support themselves, reinforcing the statement that 'HIV/AIDS is not just a cause of orphaning, but a constraint on orphan care' (Monk, 2002: 14). Where applicable, the responsibility for victims of structural adjustment programmes and poor health falls on family members in government employ who, because of their regular salaries, are judged capable of providing support to their kin. These scenarios somewhat mitigate the condemnation levied against the Malawian government, but the criticism is valid, nevertheless.

It is well documented that accountability in governments increases their commitment to fighting HIV/AIDS (e.g. Mann, 1992; Whiteside, 1999; Hsu, 2000; Pact AIDS Corp, 2001). In Malawi, however, the capacity of government to govern is being continuously undermined by the HIV/AIDS pandemic and increasing poverty, illustrating the inter-relatedness of high HIV/AIDS rates on the one hand and government corruption and tendency towards totalitarianism on the other. Many authors have cited as cause for concern in the long term the detrimental impact of HIV/AIDS on governing ability (e.g. Whiteside, 1999; Willan, 2000; Parker, Kistner, *et al.*, 2000; Youde, 2001; Fourie and Schonteich, 2001).

The escalating number of orphans is viewed as an imminent threat to security. There are fears that they will be exploited as child soldiers by those encouraging ethnic warfare (Cheek, 2002), or that they are more prone to crime because of their tragic backgrounds (Schonteich, 1999; African Development Forum, 2000). The envisioned net effect of mounting numbers of orphans, therefore, is an almost catastrophic invasion of a dispossessed, alienated and unenculturated horde of marauders. This, in the worst-case scenario, may result in a full-scale collapse of democracy (Price-Smith, 1998; Gordon, Noah and Fidas (for the CIA), 2000; International Crisis Group, 2001; United States Institute of Peace, 2002). Indeed, in July 2000 HIV/AIDS had the distinction of becoming the first health issue ever to be addressed by the United Nations Security Council (United Nations Security

Council, 2000). This highlights the necessity for the international community to address governance issues in relation to the HIV/AIDS pandemic, and ensure that governments are supported in their efforts to combat the disease and associated social issues.

Recommendations for projects assisting orphans and vulnerable children

There is general agreement among academics and aid workers that preference should be given to raising children within their own communities and, preferably, within their own extended families. This view is reiterated by the Southern African Development Community (SADC), and most governments in sub-Saharan Africa. That the preference is so widely stated, and so seldom disputed, makes its under-implementation all the more obvious and lamentable. This is especially true in Malawi, the first country in SADC (in 1992) to develop guidelines for orphan care.

> These (guidelines) are being used as an example in neighbouring countries. They recommend that orphans be kept within their communities, and argue that government should be at the centre of national orphan-care activities. (Mutume, 2001)

This begs the question: what has happened since 1992? The answer is that nothing has changed. This commitment has only ever been on paper, and has never had practical implementation or implications. This section provides some recommendations for cooperation between the Malawian government and the international community to ensure that the best interests of OVCs are served.

Policy level recommendations

Despite rhetoric emphasizing a preference for OVCs to be cared for within their own communities, and by their own families, little has been done to make this a reality by supporting those families who are already in this situation. Unfortunately, most of the policies that would serve as a support require financial commitments that are not prioritized by the government or the IFIs. Increased access to health care at no cost, financial support for families with orphans and, crucially, truly free schooling (no

hidden costs such as school uniforms and study materials) are essential for assisting families and communities to shoulder the burden of OVCs. The vast majority of rural Malawians respect education, and would attend school if financial difficulties did not prevent them from so doing. Parents and guardians recognize the need for schooling – indeed, some would assert that their children attended school, even when the children themselves claimed otherwise. The barrier to universal education is not to be found in the attitudes of the Malawian population, but rather in the financial and opportunity costs associated with sending children to school. Were schools to be truly free and, preferably, provide a meal per day per pupil, attendance rates would increase. There would be more pupils available to train as teachers in their turn, thus serving to fill the predicted shortage in teacher numbers as AIDS takes its toll on educators. Furthermore, safer-sex messages would reach a wider audience.

With regard to safer-sex messages, the Malawian government should remove the censorship currently placed on explicit teachings. Uganda's example has demonstrated that explicit messages do not encourage sexual experimentation. Indeed, quite the opposite occurs. Ugandan teens are delaying the age of their first sexual encounter, choosing to remain abstinent for longer and limit the number of sexual partners (Edward Green, personal communication). The ABCs of the Ugandan campaign (Abstinence, Behavioural change and Condoms) have proven effective, particularly since they are accompanied by dedicated ministerial support for such messages – to the extent that safer sex and ABC messages are included in most government and presidential speeches, regardless of their irrelevance to the matter being addressed (Guest, 2001).

Should community-level care not be an option, fostering or adoption by other Malawian families should be considered. The Ministry of Gender, Youth and Cultural Services is responsible for adoption and fostering laws, and the minimum standards applied in this context are ridiculously high, apparently having been modelled on UK standards. Phiri *et al.* (2001) argue for the concept of 'good enough' standards that are appropriate to the local context, respect the norms and traditions of the community, and do not serve to entangle the parents-to-be in lengthy (and

expensive) legal preparations. A revision of the relevant laws is called for in order to make this option more feasible. This would work in the child's best interests since it means that s/he is raised within a family environment. There is an ever-present risk of children being orphaned more than once due to the high mortality rates prevalent in Malawi. This is true, however, no matter what fostering arrangements are in operation.

Support for community fostering, and even adoption, must be accompanied by more stringent standards for institutions caring for OVCs. Therefore, the government must develop guidelines outlining the minimum quality of care and a basic standard of service that these organizations must provide. Potential founders and employees should be subject to an application process that would determine their motivation for establishing the orphanage, as well as ensuring that they have the finances to provide at least a minimum standard of care. Agencies established for the purpose of proselytization, rather than providing a home for children, should not be allowed. Currently, foreigners are given easy access to work and residence permits in order to open these institutions, since they will provide employment for local Malawians. This process should be reviewed, with more stringent background checks being implemented to ensure that those institutions that continue functioning do so with a genuine commitment to providing a home for children who have no other options.

These guidelines for institutions should not, however, be so strict that they cease to operate. Unfortunately, there will always be some children in need of institutional residential care – the scale of the HIV/AIDS epidemic and the associated number of orphaned children is simply too vast for all children to be absorbed by traditional safety nets. Children who are abandoned, or whose relatives refuse to take them in for whatever reason, street children who need night shelters, those who have been abused, and those who are in need of temporary or specialized care, should have access to institutions which will serve their needs (in line with Brown and Sittitrai, 1996; Wright, 1999; Subbarao *et al.,* 2001; Grainger *et al.,* 2001). Where children are temporarily placed in institutions such as infant homes, adequate attention should be paid towards their reintegration into their home communities. Remodelling infant

homes so that they better reflect the realities of village life would probably not only serve the psychosocial needs of these children better, but may also reduce operating costs.

An increased commitment to protecting the legal rights of orphaned children should also be demonstrated by the Malawian government. Property grabbing should be reversed and the perpetrators punished. An education campaign aimed at informing children of their rights would probably serve a good purpose.

Crucially, a focus on improving the status of women should be a top priority. As Geeta Rao Gupta stated in her plenary address to the Conference on HIV/AIDS in Africa (8 January 2003), the equation is quite simple: 'Gender inequality is fatal', since 'AIDS feeds...on the fault lines that inequality and poverty create in societies.' (Gupta, 2003). The fact that secondary education is nominally free for girls is a good start. The fact that few people, if any in rural areas, actually know this to be the case, is not. Furthermore, the same barriers that prevent orphans from accessing education also do so for girls. Government provision of school uniforms, a school meal and exercise books would go some way to overcoming the difficulties girls face in accessing schooling. An improved delivery of home-based care would relieve the burden currently on women, and improve their living standards. Above all, making a genuine commitment to reducing the number of people suffering from AIDS would have a positive impact on women throughout Malawi. Again, '...it is somewhat paradoxical that the effectiveness of the traditional African social system in absorbing millions of vulnerable children has contributed to the complacency of governments and agencies in addressing the orphan crisis.' (Foster, 2002: 1907). One could just as easily state that the dedication and sacrifices of Malawi's (Africa's) women have allowed the government to escape its responsibility to provide adequate medical care for those who are HIV positive. Despite waxing eloquent about the wonders of home-based care, governments fail to provide concrete support to those who are responsible for administering it. This inevitably has detrimental effects on the status and wellbeing of women. Positive actions need to be taken to pursue the

rights of girls and women, in order to allow them to lead better lives, and protect themselves against HIV/AIDS.

In much of Africa, there is still a great deal of the traditional respect for authority, elders and men, and this opens a window of opportunity for politicians. Since politicians are always in positions of authority, usually male and, often, elderly, they have tremendous sway over public opinion. In South Africa, Thabo Mbeki is regarded with near-reverence by many. I know young males there who have been influenced by his denial of the link between HIV and AIDS and believe, therefore, that condom use is not a requirement for safer sex. On the other hand, Ugandans have willingly followed Museveni's admonitions to practice safer sex because he has reiterated his position countless times, has convinced members of his government to stand up and admit to being HIV positive, and has generally taken significant steps to demystify HIV/AIDS and thus reduce the stigma attached to the disease. In Senegal, where prompt government action has managed to curtail HIV/AIDS before it took on epidemic proportions, the authority of government workers and the president have been key to this success. This clear government support for HIV/AIDS education has allowed CBOs to flourish and has promoted innovative approaches from CBOs and NGOs. Where the policy has been supportive, the populations have followed, and the first successes in Africa's fight against HIV/AIDS have been registered. Malawi should learn from these instances. A spirit of openness and frankness has proved to be effective in reducing and containing the spread of HIV/AIDS. Secrecy, shame, and false morality (false because President Banda blatantly does not obey his own cryptic safer-sex messages) serve only to promote the disease.

Recommendations for international donors

The key way in which international donors can support OVCs is to develop 'innovative mechanisms to channel resources to community groups' (Foster, 2002: 1909). Foster provides suggestions as to how this can be done, citing networks of organizations, multilayer committees, and capacity building among these groups. Crucially, however, I see accessibility to funding being the major issue facing CBOs. Applications for grants for SOCCG, for instance, were long and unnecessarily

complicated, requiring not only a mastery of the English language (there were no available forms in Chichewa or Yao!), but also an experience of filling in forms. While it is probably true that most CBOs have educated members on their committees, they may not be educated to the extent that they would feel competent to complete such a form. Provision of the documentation in vernacular languages and, perhaps, allowing an interview to contribute to the determination of eligibility would open the way to more applicants.

Furthermore, the fact that so many loans are for relatively large amounts and, therefore, require banking facilities and accountants/managers, again limits their accessibility. The infrequent distribution of large amounts of money might reduce the administrative costs of the organizations supplying the funding, but it does not serve the best interests of community groups, most of whom are unfamiliar with managing large sums of money. By supplying smaller amounts of money more frequently there would be less scope for its mismanagement and misappropriation, and more security in having a guarantee of regular sources of funds. A key constraint to supporting these groups is their lack of financial experience, history and transparency. One way of solving this problem would be for organizations supplying loans to provide the services of an accountant/auditor for some initial period of the loan. This person could keep track of the initial spending, as well as build capacity by training a member of the organization to gradually take on these responsibilities. Were several members to be trained, the opportunities for corruption would be reduced, because committee members could cross-check the financial workings of the group.

Another limitation of current donor-funding policies is that most projects are required to be finite. Limiting the period for which funding is available is unrealistic. In practice, HIV/AIDS and the orphan problem are not only a threat to Malawi's future development; they have actively retarded the state of development of the country. Currently, it would require more funding and political will to remain at the present level of development than is available, thus many in Malawi are regressing rather than progressing. To quote another volunteer involved with SOCCG 'you can't make money from orphans' (in fact, it would probably be unethical to do so). Donors must recognize this, and realize that the commitment to fund CBOs and

OVCs must not be short-term. Therefore, small grants must be available indefinitely. The orphan crisis is growing and there is no sign of HIV/AIDS rates having peaked in Malawi. Malaria and TB control programmes have been set back because of the AIDS epidemic. Until these diseases are under control, there is no end in sight to the number of associated deaths and, therefore, there should be no end in sight to funding for community groups dealing with these crises.

Finally, it is important to reiterate that the effective responses to HIV/AIDS, death and the problem of caring for increased numbers of children affected by AIDS, have come from communities themselves – a scenario echoed all over Africa. Of the responses to OVC issues outlined in the previous chapter, the SOCCG model is apparently the most effective. It cares for orphans within the context of their extended family and community, thus benefiting not only the orphans themselves, but others who are also affected by the increased vulnerability and impoverishment associated with the loss of a mother. It does so in a more cost-effective manner than any of the institutions and this, together with the commitment to the project demonstrated by the team of dedicated volunteers, promises more of a long-term solution than does the building of more institutions for housing children. The role of both the Malawian government and of international donors should simply be to support these efforts as and when they occur. The benefits of doing so have been demonstrated in Uganda and Senegal; all that remains is for this lesson to be internalized.

Conclusion: Education for the future

In Malawi, there are many repercussions for a child who is orphaned, the vast majority of which tend to be negative. For example, the loss of a mother can leave children worse off nutritionally, opens the possibility of exploitive child labour, and can harm her children's mental health and physical wellbeing. This impoverishment extends to the other children in the family that has accepted the orphans, thereby worsening the prospects for an entire generation. Many of the full repercussions of orphanhood are still under investigation, and many others may not be fully obvious for years to come. The prime example of the latter is the emotional devastation that a

child feels upon losing a parent. This is seldom addressed in orphan-care projects, or in the institutions that accept the newly orphaned child. The psychosocial toll on a generation of children who have effectively been stripped of their childhoods is one which increasingly will become apparent in years to come. Unfortunately, the issue of mental health is only slowly being acknowledged, perhaps because it is more difficult to see and assess than most other problems associated with orphanhood. That a problem is obvious and well documented, however, does not necessarily translate into responses or solutions; a key example of this is education. One way that mental health issues, safer sex messages and cultural continuity could be addressed is through the education system. By expanding schooling to include topics relevant to the social realities of many of the students, as well as providing accessible basic education, the future of an entire generation could be improved significantly.

Children's education is particularly disadvantaged following the loss of a mother, making this a key ramification of maternal death. Bicego *et al.* point out that the 'loss of a mother appears more detrimental than loss of a father with regard to educational attainment' (2003: 1247), a statement backed up by Germann (2002) and Kamali *et al.* (1996).

Lack of education is a general problem in Africa, and particularly in Malawi, which is ranked 163rd out of 173 countries on UNDP's Human Development Index (HDI). The HDI takes into account life expectancy (which has been significantly reduced in Malawi over the past few years due to the impact of the HIV/AIDS epidemic); adult literacy rate; combined primary, secondary, and tertiary gross enrolment ratio; and GDP per capita. Malawi's low position is significantly linked to low quality-of-life indicators associated with the HIV/AIDS epidemic, but its education statistics are also lower than many other low-index countries. Furthermore, Malawi's HDI value has been declining since 1995, a trend that is likely to be reinforced as the full scale of the HIV/AIDS epidemic becomes more visible, and while the number of orphans increases. Since it is highly likely that orphans are disproportionately likely to drop out of school and end their education early, this bodes ill for the future of the country; orphans make up a significant percentage of the adult population.

The importance of education is acknowledged as a key component of development, an attitude summarized by the Malawi Demographic and Health Survey as follows:

> Education is a key determinant of the lifestyle and status an individual enjoys in a society. It affects many aspects of life, including demographic and health behaviour. Studies have consistently shown that educational attainment has strong effects on reproductive behaviour, contraceptive use, fertility, infant and child mortality, morbidity, and attitudes and awareness related to family health and hygiene. (2000: 12)

Primary education is free to all, though there are many extraneous fees imposed by schools that prevent schooling from being completely accessible. Secondary school fees are generally high, certainly too expensive for the vast majority of rural families. Apparently, secondary education is free for girls (Early Childhood Development Virtual University, 2002[24]). While I was doing my fieldwork, though, I saw no indication that people knew this to be the case. In fact, discovering that this is indeed true was a surprise to this researcher, and a fact that was only learned and verified upon my return to the UK. Evidently, free provision of schooling is insufficient to ensure that children actually attend classes. Poor physical access to schools, the necessity of paying for school uniforms and equipment for students, crowded classrooms, poorly trained teachers and a generally poor provision of education are all barriers to the uptake of education. As demonstrated by the following table, a significant proportion of the population (particularly females) have never received any education, while the majority have not gone beyond primary level.

TABLE 3: DISTRIBUTION OF RESPONDENTS (%) BY HIGHEST LEVEL OF EDUCATION ATTAINED

	Women	Men
No education	27.0	10.4
Primary 1-4	30.4	29.0
Primary 5-8	31.4	40.2
Secondary +	11.1	20.4

Source: MDHS Fact Sheet, 2000

[24] http://www.ecdvu.org/ssa/downloads/Malawi_Country_Report.pdf

All indications suggest that these figures are only worsening, and the number of families affected by AIDS is a significant cause of this downward trend. It is an unfortunate fact that children are unlikely to be enrolled in schools for any significant period after becoming orphans. UNICEF (1999) points out that 68% of orphans in rural areas in Zambia were not attending school – as opposed to 48% of non-orphans. Christian Aid cites the example of Zimbabwe, where 'a study among commercial farmworkers showed (that) nearly 50% of children whose parents had died of AIDS were forced to abandon their studies. There was not a single orphan of secondary age still in school.' (2001: 10). A study on 'The impact of HIV/AIDS on primary and secondary schooling in Malawi' conducted by Kadzamira, Maluwa-Banda, Kamlongera and Swainson (2001) claims that 41% of primary and 36% of secondary students had already lost at least one parent. The study does not, however, indicate for how long orphans can expect to remain in school, nor does it provide any estimates for the drop-out rate of these children.

It is a further devastating fact that the educational establishment is also suffering from the effects of HIV/AIDS. In Zambia, five teachers die every day of AIDS-related causes (Christian Aid, 2001: 11). The South African government pointed out that for every teacher infected with HIV/AIDS, the education of 20-50 pupils will suffer (HEARD, 1999: 3). Munthali reported that 'AIDS kills one student of the University of Malawi every week' (2001: 2), adding that 'no one has had the courage to disclose causes of such deaths.' (ibid.). Certainly, not even *The Nation* has the courage to discuss the fact that teachers and lecturers are also dying of HIV/AIDS (Davison and Kanyuka, 1990; Kadzamira *et al.*, 2001; McBride, 2001; personal observations). Save the Children Fund (2003*a*) estimate that Malawi loses up to 50 teachers a month to AIDS[25].

UNAIDS pointed out that 'increasing mortality rates due to AIDS have led to discontinuity in teaching, with many pupils losing or having a change in their teachers' (2000: 132). The report expands on this by stating that:

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[25] http://www.savethechildren.org/edu/critical_issues.shtml

> a model developed by UNAIDS and UNICEF in 2000 shows that, of around 2.8 million primary school students, 52 000 would have lost a teacher to AIDS in 1999. By 1997, over 10% of education personnel in urban areas are estimated to have died from AIDS and, by 2005, this figure is projected to increase to 40%. In one district, 10% of teachers died in the first term of the 1998/9 academic year. Malawi Schools Support Systems Programme Review Report projects cumulative AIDS deaths among primary school teachers and secondary school teachers to be 2369 and 284 respectively, by 2001, and 6158 and 739 by 2006.... (ibid.)

Given the insensitivity of school policies to the needs of orphans and vulnerable children as detailed in the report by Kadzamira *et al.*, some of the reasons behind the difficulties encountered by orphans in attempting to remain in schooling are obvious. For example, while claiming that there is no overt discrimination against orphans, the authors point out that these children are often sent home because of the poor condition of their clothes or their lack of correct school uniform. Furthermore, while primary education is officially free for all, families are frequently required to pay extra charges levied by each individual school, in addition to supplying their children with exercise books, pencils and books.

Schooling practices, however, are not the only barriers to orphans remaining in class. The incorporation of orphans into a household directly increases the needs of that household. Therefore, children (particularly girls) may be kept out of school in order to help with household and agricultural tasks, and to care for younger children while the adults are engaged in employment. Once students drop out of school, they very rarely return (Kadzamira *et al.*, 2001; Christian Aid, 2001).

That orphans and the children from the families accepting orphans, routinely have to cease attending school means that the national level of education is declining significantly. Also, a key opportunity for identifying at-risk children and providing them with support (assistance that supersedes the institutional aspect of school attendance) is withdrawn. The obvious popularity of after-school clubs, many of which deal with HIV/AIDS and sex education to an extent not allowed in the formal classroom situation, indicates that many children and young adults see the benefits of

educating themselves about the risks they face when and as they become sexually active. These clubs also represent key points of access to a generation who are facing death in an unprecedented manner – the risk being both to themselves and their families.

The vast majority of HIV/AIDS-related information available to children and young adults comes from after-school clubs. As orphans are excluded from accessing these resources due to their failure to attend school, they are plunged further into ignorance. The information they need to avoid contracting the virus, which more than likely caused their orphanhood, is effectively taken away from them. Illiteracy also prevents them from accessing many other forms of HIV education, limiting not only their intellectual development and perhaps their chances of getting a job, but also their ability to protect themselves against STIs. In an area where a 'child born today is more likely than not to die of AIDS' (Christian Aid, 2001: 14) and where NGO workers assert that 'being orphaned by AIDS actually makes children more vulnerable to becoming infected themselves' (Guest, 2001: 31), limiting the access of these children to life-saving measures is nothing short of disastrous.

Despite the situation outlined above, the Malawian government still has no HIV/AIDS policy in the education sector, nor any plans on how to address the specific needs of children whose families have been affected by AIDS deaths. NGOs and other donors, however, are responding to the widespread ignorance of HIV/AIDS issues by providing relevant education in a variety of easily accessible and innovative means. Unfortunately, though, this is not linked to provision of basic education, or even literacy programmes. While the provision of schooling to children by NGOs would be a further undermining of the government's role in social support, it would be filling a gap that promises to be catastrophic for the next generation of Malawian adults.

CHAPTER 8: EXAMINING THE IMPACT OF A MOTHER'S DEATH

In assessing the impact of a mother's death on her family and community, my research has examined a variety of socio-cultural elements of Malawian society. I have analysed the role of kin in responding to the escalating numbers of maternal deaths, and community responses to the associated increase in the number of orphans. Because HIV/AIDS is a major factor associated with maternal deaths and the concomitant rise in orphan numbers, I have examined the HIV/AIDS pandemic within the Malawian context in order to shed some light on the community-level responses that have emerged, including that of institutional care of orphans outside the community setting. That HIV/AIDS disproportionately affects females, and that poverty is being 'feminized' are both statements that reflect the reality of life in the developing world. This thesis reinforces the already large body of evidence that women bear the primary burden of maternal death and its ramifications.

This chapter draws together the fieldwork results presented in previous chapters to argue that a mother's death is truly disastrous for her children, kin and community. It highlights the fact that a mother's death is, in fact, synonymous with the disintegration of her family and is accompanied by the creation of a new, further impoverished, household. This devastation is particularly profound due to the accelerated rate at which maternal deaths are occurring nation-wide. There are profound implications, therefore, for the country as a whole.

The chapter concludes by reiterating some ways in which orphan care in Malawi can be improved, while also outlining the associated challenges for the Government of Malawi and local and international assistance agencies. It further emphasizes the urgency for such action.

Impact on children: varied and profound

Physical survival is jeopardized

Any adult female death is particularly detrimental to the survival and wellbeing of surviving children previously in her care. This is due to a combination of cultural and social factors, primarily matrilineal kinship relations. Poverty-induced migration of adult males for employment opportunities reinforces the matrilineal structure by creating a stronger dependency of children on their mothers than on their fathers. Young children, in particular, are at risk upon the death of their mother. Traditionally, most children are breastfed for their first two years of life and, in light of extreme poverty in the research area, this is generally their main source of nutrition for that period. The younger a child upon the death of its mother, the less likely are its chances of survival, since few families can afford infant formula for a baby not yet weaned. Older toddlers whose breast milk intake was supplemented with other foods have a better survival rate though they generally become malnourished due to the loss of a key source of nutrition.

Additionally, most families depend upon subsistence agriculture for the bulk of their diet, and since women make up 69% of full-time farmers (Gilbert, Sakala and Benson, 2003[26]), their death has an extremely detrimental effect on household food security. The death of a mother, therefore, has nutritional ramifications for all of her children. While female children may be required to work in the fields after their mother's death, they may not yet have the physical strength to carry out many of the tasks, thus the harvest will suffer even with replacement labour. In addition, with high-energy expenditure on labour, the children's nutritional requirements for growth may not be met and they may become stunted.

All of the orphans whom I encountered suffered from malnutrition to varying degrees. This was true too of the non-orphans, however. Cumulative losses of productive adults reduces the quality and amount of available agricultural produce, and the increased dependency ratio in those families that incorporate orphans

[26] http://web.africa.ufl.edu/asq/v6/v6i1a9.htm

decreases the amount of food available to each member of the household. Thus, the nutritional status of everyone in the family is worsened by the increase in poverty that occurs with the loss of a productive adult member. That the death may have been preceded by a costly period of illness and will definitely have culminated in the expense of a funeral, are also factors in the worsening economic status of affected households.

Devastating emotional aftermath

Orphans also suffer emotionally from the loss of a mother, a bereavement that is often exacerbated by cultural norms that demand respect for adults in authority along the lines of 'children should be seen and not heard'. Traditionally, children cannot discuss emotional or private issues with their parents because that level of familiarity would be interpreted as a lack of respect. Rather, girls confide in a maternal aunt or grandmother, and boys in their maternal uncle or grandfather. These relationships are characterized by high levels of affection and camaraderie, and it is to these individuals that a child will turn for emotional support and comfort. Upon the death of a mother, however, this changes drastically, particularly for girls. The most common scenario in the research area is for children to be incorporated into the household of the aunt who was closest to the deceased mother, and this is usually the same person with whom female children will have developed the closest relationship. Once this aunt becomes the primary caregiver, she assumes the role of mother and, with it, the same level of respect due a mother. In effect, she distances herself from the previously supportive and affectionate relationship she has shared with her nieces. Thus at the very time that girls are in most need of support and caring, tradition rules that this should be withheld.

Boys fare slightly better than do girls, since it is unlikely that they will physically move in with a maternal uncle. The uncle's role as confidante is unchanged. He may be involved in providing support for the orphans, but this is usually financial, and is channelled through the aunt who is caring for them.

Matrilineal descent patterns in the research area dictate that orphaned children belong to their mother's lineage. When their mother dies, children are incorporated into their maternal extended family, either through an aunt or grandmother. In instances where orphans move in with their grandparents, there is the possibility of orphans maintaining their usual relationships with aunts and uncles, but the scenario that includes caregiving by the elderly usually occurs either because there are no living aunts, or because the aunts are already overwhelmed looking after other orphans, do not have the time or energy to provide comfort for their nieces.

The tradition of respect is compounded by a cultural emphasis on the necessity of 'forgetting' the dead. Orphans are encouraged by kin and community to 'forget' their mother's death as quickly as possible and this is understood to be best accomplished by not talking or thinking about her. The consequences of failure to forget include illness and possibly death (supposedly more common among younger children who do not understand the need to look only to the future). This emphasis explains to some degree the reluctance of many orphans to discuss the impact their mother's death had on them and their family. In the instances, though, where orphans were willing to discuss such issues with me, there were clear indications of depths of pain that were not being addressed at all. Supportive interventions that allow orphans to express and resolve their feelings of grief and loss would respond to a presently unmet need and, hopefully, mitigate some of the negative psychosocial impact of being orphaned.

While widowers may initially maintain some contact with their children, the necessity of travelling for work frequently means that they eventually lose touch. This loss of contact is likely to occur too should the father re-marry. Poverty-induced migration for work may have caused a father to be working away from the home, often at some distance, prior to his wife's death. Thus ties between a father and his children, already weakened prior to the mother's death, have an increased likelihood of being severed with his children's incorporation into his wife's extended family. Maternal orphans, therefore, are extremely likely to lose a father as well, making them *de facto* double orphans. When fathers die, households may lose a source of

income, but they generally remain intact, with children staying with their mothers and having their support system maintained. Obviously, children suffer emotionally from the death of either parent but, within these kinship systems, the social ramifications of a father's death are more limited than are those following a mother's death.

Transmission of cultural knowledge is threatened

Subsequent to a mother's death, aunts and grandparents take on the role of primary caregiver, with whom children have relations characterized by respect and deference rather than familiarity and affection. Not only do children lose emotional support but they also lose their relationship with prime cultural educators. This represents a significant loss, and one whose impact cannot yet be fully assessed. Furthermore, while the majority of orphans remain within their villages subsequent to their mother's death, there is a significant minority who end up in institutional care, or as street children in urban centres. Children in these last two are almost certain to lose cultural awareness and become alienated from their roots and traditions. Also, since orphans are likely to lose land-rights once removed from their communities (Kamchezera, 2001), whether this removal is to a town or an institution, they no longer have the opportunity to pursue a traditional lifestyle. This cultural alienation is likely to have negative ramifications in the near future, effects that may be worse if the traditional support system continues to be undermined as is currently occurring.

Inappropriate education and vocational training

Despite the fact that primary education is statutorily free for all, families afflicted with caring for orphans seldom have the capacity to send children to school. This is largely due to the extraneous fees imposed by schools for items such as books, pencils and notebooks, and the requirement of a school uniform – further expenses that families can ill afford. There is evidence to demonstrate that orphans are less likely to be educated than non-orphans, since they are more likely to be withdrawn from, or drop out of, school. It would not be surprising, however, to see this difference decreasing in the future, as families as a whole become more

impoverished and are less able to send *any* children to school. Girls will increasingly be required to help with housework and agricultural work, as well as caring for sick relatives and other children, while boys will have to engage in agricultural work and trading.

Future employment possibilities are reduced by a lack of schooling, and children who do not attend school also miss out on the after-school clubs that are key to providing information about HIV/AIDS and STIs. This means, therefore, that their physical health is jeopardized due to a lack of exposure to messages regarding safer sex.

Attempts to provide orphans with vocational training are small-scale, largely unsustainable, and highly repetitive – the same programmes are implemented throughout the country with very little innovation. Furthermore, these programmes often fail to take into account local market realities. Instead of providing diversification of training, the programmes focus on activities such as carpentry and sewing that have proved easy to implement elsewhere. They therefore run the risk of saturating the market. In those instances where innovative projects have been implemented, however, they are highly successful and significantly improve the livelihood of the trainees. Such novel programmes are a promising way forward, therefore, if a concerted effort is made to make skills training relevant and profitable for the participants. Vocational training also needs to be more widely accessible. Currently, only a small minority of orphans have access to such.

Impact on kin: no time for grief

Members of the extended family also experience grief at the death of one of their kin. For many, however, this grief may be subsumed under the stress of the added responsibility that comes with caring for any orphans resulting from that death. For the person who incorporates the new orphans into her family, the added burden of feeding, clothing and caring for more children despite already limited resources, can be overwhelming. Even for those who are not directly caring for orphans, there is some added stress. Maternal male kin do not usually incorporate orphans into their

household but they do contribute financially to the upkeep of their deceased sister's/daughter's children wherever possible. Thus the resources of other family members are stretched further, illustrating the widening impact of a maternal death.

Discussions with informants on the emotional impact of death were seldom fruitful since talk soon veered towards the physical and mental drain of the daily struggle in caring for numerous children. Caregivers obviously experience high levels of stress but they have little time to indulge their grief at losing a beloved sister or daughter. Despite this excruciating load, I did not meet a single person who would act differently if presented with a choice. Children are incorporated into extended families willingly and lovingly, and families simply do whatever is in their power to ensure that necessities are acquired for the whole family.

There are indications from countries surrounding Malawi, where the HIV/AIDS epidemics are more mature, that this may not continue (e.g. Bicego *et al.*, 2003; Save the Children Fund, 2003*b*). The extended family support system may quickly be overwhelmed by excessive orphan numbers and increased mortality among productive adults. This devastation may, in turn, result in child abuse, child-headed households, a growing problem of street children, and further impoverished elderly carers who are at an age where they should themselves be cared for. It is crucial, therefore, that development interventions that support and reinforce existing community coping mechanisms be implemented now while they are still sufficiently intact to bear this burden.

Households are impoverished

The drain on family resources that occurs with the incorporation of orphans into a household is usually accompanied by other expenses that further impoverish the household. Many maternal deaths are often preceded by lengthy periods of illness, periods that are costly to a household in two main ways. Firstly, there is the financial cost of medication, consultations with doctors or traditional healers, and travel to health-care facilities. Secondly, there are the opportunity costs of requiring females to care for the sick, and the associated loss of productive farm workers. Girls are

highly likely to be withdrawn from school to look after ailing relatives, and adult women may lose valuable time that could be spent in agricultural activities that provide food for their families. The increased government and international donor emphasis on home-based care programmes as being the most viable option in dealing with the escalation in HIV/AIDS is likely to exacerbate the already grim outlook for women as the responsibility for health care is transferred from government to individuals.

Finally, after the significant costs of illness have been borne, there comes the added expense of a funeral. Funeral costs are tremendously high, and when done in true traditional fashion, a funeral can bankrupt the hosting family. Relatives from all over Malawi must be summoned, and the bereaved usually pay their transportation costs. Both relatives and community members are required to attend a funeral in order to show their respect for the deceased, and while they make financial contributions at the funeral, this seldom offsets the costs of transporting, housing and feeding all of the attendants. Obviously, while attending a funeral (a minimum of a day-long affair, occasionally up to three days long), agricultural and income-generating work is put on hold. Few families can realistically afford this.

For this reason, funerals are being scaled down, and attendance is becoming less obligatory. With so many funerals occurring so frequently, it is impossible for them to be carried out in line with traditional regulations. Thus, another tradition is being lost. While the avoidance of such expenses may be positive for the families involved, the abridgement of periods of mourning is not. Funerals allow the bereaved to express their grief openly, and to receive comfort from everyone. Though mourning can continue for up to a month following the funeral, it is understood that the intensity of these emotions will decrease as time elapses. By providing a structured mechanism for managing grief, funerary rituals serve an important psychosocial purpose. It is only after this period of mourning is over, for example, that children are required to 'forget' their deceased mother, but they will have experienced love and sympathy during this time, thus making the adjustment somewhat easier to bear. Yet, as funeral ceremonies themselves are scaled down, so are these periods of

mourning. Death is becoming more frequent, more commonplace and, therefore, less emphasis is placed upon the aftermath. Overt grieving, as much as funerary rituals, is being curtailed.

A final cost worth mentioning occurs primarily when a male dies and opportunistic relatives of his indulge in 'property grabbing'. This is the most-oft cited feature differentiating the death of a man from that of a woman, and is extremely detrimental to the remaining kin. Unfortunately, however, in households affected by HIV/AIDS, a father's death may occur in conjunction with that of a mother. Thus orphans face the loss of their father (a significant financial loss in itself) as well as the loss of any form of material wealth they possessed. Their new caregivers also bear the burden of replacing these goods, such as clothing or eating utensils, or, more often, the new extended family must manage without.

The costs associated with a mother's death come from various sources and, in combination, they are proving overwhelming to kin. Despite this, however, kin remain the primary source of aid for orphans who continue to be incorporated into the extended family structure. How much longer this will remain true, however, is open to debate, as the challenges to this system mount up.

Impact on community: a scaled up family problem

As highlighted previously in this thesis, there is a significant confluence between the categories of 'kin' and 'community'. To a large degree, one's community consists of (maternal) kin, since members follow matrilocal rules and settle within the vicinity of other maternal kin. Kinship ties can often be traced through entire villages, becoming progressively weaker on the physical outskirts, but still remaining within the extended family. Households are interdependent. Therefore a death in one has ramifications for many other households, and cumulative deaths destabilize community coping mechanisms. Communities, therefore, face many of the same problems as do kin, though the effect of cumulative maternal deaths becomes increasingly obvious at a community level. When multiple families are struggling with the issues of raising children with fewer productive adults, the scope of the

crisis is made clearer than when examining it from the point of view of a single family. It is also at the level of the community that the impact of the HIV/AIDS pandemic becomes clearer, since seldom does a week go by without a member of the community dying, or having to attend the funeral of a relative.

Fortunately, though, there are examples of communities responding positively to these problems, through the formation of organizations that aim to support orphans and the families caring for them. Such organizations are limited in number and scope, but they address issues within a holistic framework while maintaining orphans within their socio-cultural context. Importantly, funding and support are not provided strictly for orphans, but rather for the families who look after them, recognising the fact that incorporating orphans into a household impoverishes the household as a whole, and that the individual orphan isn't the only individual affected by a mother's death. These organizations are indicative of a positive trend. However, the scale of the HIV/AIDS epidemic and associated orphan numbers threatens to overwhelm them. If such community organizations can be encouraged, and reinforced by outside support, then communities as a whole may potentially be strengthened. By enabling the continuation of the community structure, orphans and children affected by AIDS may be able to grow into a healthier and more familiar world, and the dislocation and alienation predicted by many may not occur.

Impact on Malawi: the imperative to address the future

The aftermath of maternal death has proven overwhelming to communities across the country, and the government is struggling to respond adequately. Efforts have been made, but these lack financial resources and political commitment. Failure to address the HIV/AIDS epidemic early on is having disastrous effects. Unfortunately, the Malawian government even now lacks the political will and resources to successfully confront this epidemic, and to tackle the growing orphan problem associated with maternal deaths. Rather than learn from the success of neighbouring Uganda, Malawi has followed the lead of countries such as Kenya and South Africa, who have systematically denied the true potential of social havoc that could be associated with HIV/AIDS if it is not addressed urgently. Socio-cultural norms prevent full and frank

discussions regarding sexuality, and hence sexually transmitted infections, and have influenced government censorship activities. Such censorship has contributed to the failure to provide adequate safer-sex education that has, in turn, directly jeopardized the lives of Malawian women and contributed to the numbers of dead and dying mothers.

Furthermore, the fact that President Muluzi and other government ministers reinforce unequal gender relations through their behaviour, presents a significant barrier to gender-equality messages being generally accepted. A lack of women's empowerment increases their risk of contracting HIV/AIDS and, hence, of dying and leaving behind a family of orphans.

Failure to address the HIV/AIDS epidemic is also negatively influencing the ability of the government to carry out its duties. As ministers and government employees succumb to the illness, or take time off for funerals and/or to care for sick relatives, government capacity is undermined. As this vicious circle is perpetuated, plans of action that could prevent the dissolution of community response strategies to growing numbers of orphans are not receiving the full extent of possible government support. Too often, governmental plans focus on large-scale development projects rather than assisting small-scale, local initiatives, and a general lack of funding and infrastructure results in an inability to provide social security for orphans. The regulations of the International Finance Institutions, which require further reductions in the already inadequate social services, indicate that this deterioration is unlikely to be halted.

Donors and assistance agencies operate within inadequate frameworks

A desire on the part of the Malawian government to encourage foreign donations, without providing adequate and transparent information about the institutional arrangements, objectives and strategies governing their use, means that there has been a significant increase in unregulated orphan-care institutions. There are no operational guidelines for such institutions and, therefore, no standards of care to which managers and owners can be held accountable. Community efforts to address

HIV/AIDS and orphans' problems have met with limited assistance from the government. Unfortunately, it is mostly left up to communities to help themselves. Their capacity to do so may not survive for long without external assistance.

Structural inadequacies of donors prevent effective assistance

An increasing amount of social service assistance is being provided by international donor agencies and NGOs, rather than the Government of Malawi. Despite official rhetoric on the part of the majority of donors stating that assisting communities' own efforts is of primary importance however, this assistance fails in its attempts to support families caring for orphans. Crucially, it suffers from institutional inflexibility. Donor agencies have strict guidelines influencing the distribution and allocation of funds, particularly regarding the duration of loans and accountability requirements to which recipients must adhere. Many of these requirements effectively exclude CBOs from being eligible for assistance. Addressing the shortcomings of donor agencies is key to providing effective solutions to the orphan crisis impoverishing Malawi, as elaborated upon below.

The way forward?

It is difficult to avoid sounding alarmist when pointing out how close local kinship structures are to full-scale decimation. At the same time, however, downplaying the level of stress that kin and communities find themselves faced with must be avoided. Currently, there seems little likelihood that, without external support, communities will survive the next decade with their traditions and socio-cultural structures intact. This will represent a loss of immeasurable proportions, and it will be a loss that regional politicians and the international community could avert with the appropriate political action.

Enhancing mechanisms for support of CBOs

Despite the overwhelming nature of the problems currently facing families and communities, the full scale of the HIV/AIDS and orphan epidemics have not yet

been realized. The informal, kin and community-level support networks have been severely compromised, and continue to be undermined on a daily basis with each additional maternal death, yet to date they remain largely functional. This remarkable resilience is to be commended, and has the potential to be revitalized by capacity-building grants and technical assistance from international donors. Currently, individual donors and small NGOs are leading the provision of support to CBOs, but a growing recognition of the importance of such networks suggests that larger donors might follow this trend and, hopefully, do so in time to prevent the full-scale destruction of such communities.

It is now generally accepted that community-based care for orphans is not only preferable, but also more realistic than institutional care, which simply could not cope with the sheer numbers of orphans. While there remains a place for a limited number of institutions such as infant homes, which respond to the specific needs of young children who have lost a mother, and do so strictly for a limited period, or for those children who fall outside community support networks (e.g. street children), institutions alone are not a realistic or effective response to the orphan crisis. Yet despite this acknowledgement, many donor agencies are paralyzed, incapable of providing community-level support due to their own organizational structure and procedures.

I have pointed out previously that community-based responses to growing orphan numbers, like that of SOCCG, are rare in Southern/Central Malawi. I maintain, however, that they would be more common were communities to see the success of such initiatives – success that requires external assistance in the form of regular and long-term financial assistance and full-scale political commitment to making the future of orphans a matter of highest priority. The problems facing communities as summarised in this chapter are growing and the consequences for individuals and communities, in fact Malawi as a whole, are severe. Urgent attention and action is needed. The unfolding tragedy of maternal deaths and increased numbers of orphans needs to be paramount on the list of international priorities, and given the support that is desperately required.

Changing the way that funding is accessed and administered is key to ensuring the disbursement of funds to community organizations. Crucial to this endeavour are the following points:

- providing application forms in local languages in order to make them more accessible;
- where necessary, providing guidance to the community representative completing the application;
- being open to innovative ways of channelling resources to communities, including building capacity, using networks of organisations, and/or multilayer committees;
- dealing with issues of corruption by training local accountants, a group of whom (perhaps from networked organisations) could track finances in order to provide a check and balance on other committee members, and/or providing a visiting accountant to check finances in collaboration with local accountants;
- a willingness to provide smaller amounts of funding; and, crucially,
- a commitment to providing such funding for the long-term.

It is unnecessary for donors to develop their own responses to orphan care. Instead, they need to listen and observe. There are models of community care, such as that found in Songani, which can be built upon and replicated. By appropriately funding such community initiatives, culturally acceptable, cost-effective and participatory solutions can be implemented; solutions that build capacity at a local level and prevent further deterioration of native culture. The benefits of such interventions would extend beyond the needs of OVCs and the families caring for them, and would serve to build capacity at a wider level. Thus, an effective model that addresses the problems of OVCs would also provide transferable skills for use in other development contexts, and serve to address impoverishment within a wider framework.

Health promotion and HIV prevention

In conjunction with the above reforms on the part of donor agencies, a number of social commitments would also serve to assist orphans. As HIV/AIDS is perhaps the most significant contributor to mortality rates in Malawi, prevention efforts should be more closely modelled on such successful efforts as evidenced, for example, in Uganda and Senegal (e.g. African Development Forum, 2000; Gow, 2002). The lack of political will in Malawi to seriously confront the HIV/AIDS epidemic, the high levels of adult mortality, and the growing numbers of orphans is both striking and incomprehensibly short sighted.

Essential to successful anti-HIV/AIDS campaigns is an ongoing openness about the disease and an emphasis on multifaceted prevention efforts. The Ugandan government, for example, introduced urgent measures to raise awareness about HIV/AIDS and direct attention to those already suffering from HIV/AIDS through continual discussions about previously taboo topics. Senegal has introduced reproductive health and sexuality education in schools. Malawi has failed to embrace the required frankness about sexual matters that is a prerequisite for successful prevention efforts. A national debate about gender inequalities should also be sustained, since these are inextricably linked to maternal death rates.

Gender awareness

The lack of gender equality is in large part responsible for HIV/AIDS transmission and accounts for many female deaths. Yet despite widespread recognition of this fact, there remain too few interventions aimed at improving women's status within society. Solutions to the problems arising from maternal deaths must, of necessity, confront women's status in society. This would be facilitated with clearly stated national policies that explicitly link unequal gender relations, lack of health care provision, HIV/AIDS infections, maternal deaths and orphans, and provide a framework within which these issues can be addressed.

Education

Supporting education in order to ensure that children affected by the HIV/AIDS epidemic can access schooling is a crucial step to mitigating the impact of maternal deaths. Maternal orphans are more likely than other children to be withdrawn from school, primarily due to the lack of family resources to provide these children with school supplies and uniforms. School serves as an important point of access for children to safer-sex messages through after-school clubs. These same clubs could also serve as a means of providing orphans with counselling, thereby providing an opportunity for them to discuss the emotional and psychological effects of orphanhood that, currently, are ignored to the potential detriment of these children's mental health. Furthermore, education opens up an array of career choices that are simply unavailable to the uneducated and illiterate, and would further mitigate the negative impacts or orphanhood. Education is a key to providing a better future for OVCs, as well as being an accessible intervention point for development initiatives to utilise.

Regulation

The Malawian government needs to implement and enforce legislation specifically aimed at protecting the rights of orphaned children, including those who are raised outside of their home village. Despite being a signatory to the United Nations Convention on the Rights of the Child, there has been little attempt to provide a local interpretation of such rights, and to present methods for supporting such rights within the Malawian context. Crucially, land rights of orphaned children must be protected legally, and inconsistencies between the national legal framework and traditional law systems must be satisfactorily resolved. Property grabbing, for example, was recently made illegal by the Malawian government, and the right of a widow (though not orphaned children) to her household property has been upheld within the Malawian constitution. Traditional law, however, operates outside the context of the national constitution and continues to uphold the rights of the husband's relatives.

Government guidelines outlining minimum standards of care for orphanages would be useful. Part of these guidelines should include efforts to ensure that institutions

better reflect rural realities, thus preparing children for life after the institution (particularly necessary for infant homes). Encouraging the establishment of such institutions in rural rather than urban areas would go some way towards providing a more community-grounded experience of institutionalization. There is also a need for these early experiences in innovative orphan care to be documented and analyzed to inform subsequent developments.

Conclusion: The time to act is now

Malawi benefits from a solid traditional background that, partly due to Banda's commitment to keeping people on the land, has remained largely intact. There are, however, strong indications that this structure is beginning to erode. Evidence of this is the increasing numbers of abandoned children and children being cared for within institutions. Mortality rates within villages suggest that the incidence of child-headed households will also increase dramatically in the short-term. Families are already beginning to express fears of being overwhelmed by growing orphan numbers, yet the full impact of AIDS-related mortality is still to be felt within the country. These expressed fears are a clear indication that the kin structures, already unravelling under severe stress, is likely to be devastated within a relatively short period.

Historically, the traditional kinship structure has proven to be resilient in the face of hardships, but the scale of maternal deaths and orphan numbers is an unprecedented phenomenon. These structures may not, therefore, survive without external assistance. As this thesis has maintained, the death of a mother is devastating to her family and community. Yet as long as there remain families unaffected by such losses this devastation will not provoke a full-scale collapse of cultural structures. Unfortunately, however, it is unlikely that any families will remain unaffected by HIV/AIDS, maternal deaths and orphan numbers for much longer. Currently, maternal deaths are at a high level. As yet, there is not the critical mass that will provoke social destruction. However, this point is not far away. Crucially, assistance should be provided to communities *before* this not-too-distant point is reached, while there remain structures upon which to build.

It would not be melodramatic to assert that if the international community fails to reinforce the existing kinship structure in Malawi now, it will not be long before the same community realizes that it stood by ineffectually witnessing the devastation of a society as we know it. What will emerge in place of the current socio-cultural structure is impossible to predict with any certainty, but the prospect is grim. Predictions of socio-cultural fragmentation and a conflict-prone society are likely to be realized if the appropriate support is not provided to prevent this process from occurring.

Innovative interventions will enjoy successes if the strengths of community coping mechanisms are built upon. At the same time societal changes provide an opportunity to re-examine gender inequalities and the relations between donors and recipients. Against a global discourse of effectiveness and efficiency, the challenge is for the government and donor agencies alike to respond to local initiatives and associated appeals that contribute effectively at the community level. The impact of a mother's death on her kin, community and country though devastating can and must be reduced. Local responses present a significant challenge to the operations of large institutions. They provide glimmers of hope, indicating the potential for future strategies to care for orphans by incorporating those methodologies that have proven successful – both in Malawi and elsewhere.

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APPENDIX 1: LETTER OF RESEARCH CLEARANCE

UNIVERSITY OF MALAWI

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UNIVERSITY OFFICE
P.O. BOX 278
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MALAWI

Ref:

24th April, 2001

Ms. Chenoa Mary Putter
Centre for International Health Studies
Queen Margaret University College
Corstorphine Campus
Edinburgh EH12 8TS
Scotland
United Kingdom

Through: The Director
Centre for Social Research
University of Malawi

Dear Ms. Putter,

CLEARANCE FOR RESEARCH PROPOSAL "AN INVESTIGATION INTO THE SOCIAL IMPACT OF A MOTHER'S DEATH ON THE FAMILY AND COMMUNITY IN MALAWI"

Your research proposal submitted to us through the Centre for Social Research under the above title has been reviewed.

I am pleased to advise that the University of Malawi has approved the research proposal for implementation towards attainment of the PhD degree. The project's permit reference is CSR/01/04/01.

24th April, 2001

Ms. Chenoa Mary Putter
Centre for International Health Studies
Queen Margaret University College
United Kingdom

The University of Malawi requires payment of affiliation fee of US$500 to the Centre hosting you to cover administrative costs. The fees may be paid on your arrival in Malawi.

It is expected that at the end of your research you will submit to the University Research Co-ordinator's office, three copies of your report or any publication(s) that may result from your research in Malawi. These copies will be distributed as follows: One copy to be retained by the Centre for Social Research, one for the University of Library and the other for the National Archives.

We are looking forward to your tenure at the University of Malawi and wish you all the best in making arrangements for your projects.

Yours sincerely,

E.Y. Sambo
UNIVERSITY RESEARCH CO-ORDINATOR

CC: Vice-Chancellor
University Registrar
Director, Centre for Social Research

EYS/sm

APPENDIX 2: INTERVIEW QUESTIONS IN ENGLISH

Interview questions for initial interviews with case-study families

Identification questions

1. Name
2. Age
3. Sex
4. Position in household
5. Relationship to children in the house
6. Number of people living in your household
7. Relationship to the others living in the household
8. Tribe
9. Matrilineal or patrilineal descent?
10. Religion
11. Level of education
12. Main source of income: agricultural, business owner, trader, professional, other
13. Number of wives
14. Number of wives prior to the one wife's death
15. Date of wife's death

Kinship, personhood and pregnancy

1. How would you define a 'family'?
2. How do people act towards each other to show that they are a family?
3. Could you please tell me what men and women do in a family? What are they each responsible for doing?
4. How does a woman know that she's pregnant?
5. Could you tell me if there are any special customs or rituals that a woman must do when pregnant?
6. Why does she do these things?
7. Can you give me examples of any special rituals that a woman should do after giving birth? (Why?)
8. Can you give me examples of anything that a woman specifically can NOT do while pregnant? (Why?)
9. Can you give me examples of anything that a man should do while his wife is pregnant? (Why?)
10. Can you give me examples of anything that a man can NOT do while his wife is pregnant? (Why?)
11. Can you give me examples of foods that a woman should eat while pregnant? (Why?)

12. Can you give me examples of foods that a woman should NOT eat while pregnant? (Why?)
13. What, in your opinion, is the relationship between a woman and the fetus? For example, is the fetus part of the woman, or understood as a separate human?
14. Using the last birth you remember as an example, can you tell me how births are managed in your experience?
15. In your experience, where do women usually give birth?
16. What are the roles of the people present at a birth?
17. Who makes the decision about whether a birth should take place at home or in a hospital?
18. When is this decision made (at what stage during pregnancy or labour)?
19. How would you define a normal pregnancy?
20. How would you define an abnormal pregnancy?
21. How would problems related to pregnancy be recognised, and by whom?
22. If a pregnancy is problematic, how is this dealt with?
23. How are problems related to childbirth recognised, and by whom?
24. How are childbirth difficulties dealt with?

Parenting

1. How would you define a 'mother'?
2. How would you define a 'father'?
3. What are the roles and responsibilities related to being a parent?
4. Do you feel that being a parent is important to you personally? (Why?)
5. Do you think being a parent is important to society? (Why?)
6. How do you act and behave as a 'good' parent?
7. At funerals, do Malawians have to behave in a certain way if it's their mother's funeral?
8. If 'yes', can you give me some examples?
9. Is this behavior different if it is their father's funeral?
10. If 'yes', can you give me some examples?

Orphanage-related questions

1. Why did you decide to send your child/children to the orphanage after your wife died?
2. Who made this decision?
3. How has your child adapted to being back among his/her family after living in the orphanage for two years?
4. How many children do you have?
5. Are all of your children alive?
6. Are all of your children living with you?
7. If 'no', where are the children who aren't living with you, now living?
8. Why were these children sent _____?
9. Who made the decision to send these children _____?

HIV/AIDS

1. How would you explain HIV to me?
2. How would you explain AIDS to me?
3. Do you know anyone who is HIV positive?
4. Do you know anyone who has died of AIDS?
5. Do you think people are treated differently if they're HIV positive?
6. If yes, can you describe how they are treated differently?
7. Are AIDS deaths treated in a different way to other deaths?
8. If 'yes', how are they treated differently?
9. Do you think there's a difference in the way an HIV positive person is treated if they're male or female?
10. If 'yes', how are they treated differently?
11. Are AIDS deaths treated differently to other kinds of deaths?
12. If 'yes', can you describe how they are treated differently?
13. Have you ever been tested for HIV? You don't have to tell me the result of the test, I'd just like to know if you've actually had the test.
14. If you have been tested, do you mind telling me why you made the decision to be tested?

Death

1. How are women's deaths different from men's?
2. What are the specific procedures followed with the body of a dead woman?
3. How do these differ when it is the body of a dead man?
4. Does the way the body is treated differ if the person was a parent or not?
5. If 'yes', can you describe how it is treated differently?
6. Can you tell me about the differences in the funeral rituals between a woman's death and a man's death?
7. Who expresses emotion at funerals?
8. How are emotions expressed by kin at funerals?
9. Does emotional expression differ if the dead person is male or female?
10. If 'yes', how is it different?
11. What, in your opinion, is 'the best way' to die?
12. Can you give me examples of some of the specific problems facing your family after your wife's/mother's/sister's death?
13. How do you think the ages of your children at the time of your wife's death made a difference to the way the death affected your family?
14. Do you think it is more difficult for children if their mother dies when they are younger or older?
15. Can you tell me why you think this?
16. Does the number of children left after a mother's death make a difference to the family?
17. If 'yes', can you tell me why?
18. Were there any traditional rules your family had to follow after your wife's death?
19. If 'yes', what were they?
20. Were there any specific acts that had to be performed after your wife's death?

21. If 'yes', what were they?
22. Are there different and specified periods of mourning for different people?
23. If 'yes', what are they?
24. Are specific things done to mark the anniversary of a death?
25. If 'yes', what are these things?
26. Who performs these acts?
27. Do you believe in spirits?
28. What do spirits do for you?
29. Are there any health problems that you're aware of that are caused by bereavement?
30. How has your life changed as a direct result of your wife's death?
31. What activities do you do now that you wouldn't have done before?
32. What don't do you do now that you would have done before?
33. Has your relationship with your children changed as a result of your wife's death?
34. If 'yes', in what way has it changed?
35. Has your role as a father changed as a result of your wife's death?
36. If 'yes', in what way has it changed?
37. How have your social contacts and networks changed (if at all) as a result of the death?
38. Have you remarried after your wife's death? (if no, go to question 99)
39. If 'yes', how long after her death did you remarry?
40. Why did you make the decision to remarry?
41. Has your new wife accepted your children from your previous marriage?
42. If 'no', why do you think she hasn't accepted them?
43. If 'no', do you intend to remarry in the future?
44. Do you think that your new wife will accept your children from your previous marriage?

Follow-up interview questions

Though I had this guideline to follow for follow-up interviews, this wasn't followed very strictly. Follow-up interviews were significantly less structured than others.

1. Do women in your village go to traditional healers when they are pregnant?
2. Did you ever consult a traditional healer when pregnant? Why?
3. Does pregnancy affect a woman's body temperature? How?
4. What else affects a woman's body [man's] temperature? Does infidelity?
5. What does a woman have to do to maintain a regular body temperature? [man?]
6. Do you know of any traditional healers who treat AIDS? If yes, how do they treat it?
7. Do you know of any religious people who treat AIDS? If yes, how do they treat it?
8. do you think there is any difference between dying of AIDS and dying of Malaria?
9. How do you feel about death?
10. Do you think about death ever? Why? What do you think about it?

11. What do you think is the most important difference between men and women?
12. How do you decide how many children you will have? Who makes this decision?
13. What kinds of contraceptives have you heard of? Have you used, or are you currently using, any of these contraceptives?
14. What do you think of chishango?
15. How does a girl become a woman?
16. How does a boy become a man?
17. Do you believe in spirits? If yes, what kind of spirits do you believe in?
18. Do your ancestors influence your life in any way? If yes, how do they influence it?
19. Can you appeal to your ancestors for help? If yes, how do you appeal to them?
20. Should women be married before getting pregnant? If yes, why should they be married?
21. Should men be married before fathering children? Why?
22. At what age do women get married? And men?
23. Are there reasons other than nutritional that parents feed their children?
24. Have you been to many funerals?
25. How does going to a funeral make you feel?
26. I have seen that younger children are usually very attached to an older brother or sister. Is this usually the case? Can you explain to me why this happens? Is this more or less true in families where the mother has died?
27. After a mother dies, how do you decide who will look after the children?
28. I have seen families where the mother has died and where the father, even though he is still alive, has left the family and doesn't have any more contact with his children. Why do you think this has happened?
29. Do you think AIDS is a danger to your community? Why?
30. Do you think AIDS is a danger for your family? Why?
31. What do you think are the most serious health problems in your community? Why?
32. How do you decide where to bury a person? Who makes this decision?

General Interview Questions

These questions were directed at individuals who did not classify as a case-study, but who could provide some commentary on the research topic.

1. What options do you see a family having to look after their children when a mother dies?
2. Which is the most common option used by people in your opinion?
3. Why do you think this is the most common?
4. Do you think that families discuss what will happen to the children in the event of one of the parents dying?
5. What do you think of Malawi's official definition of an orphan as 'a child under the age of 18 who has lost a mother'?
6. What impact do you see orphans having on communities?

7. In your experience, is the 'orphan problem' different from, say, ten years ago?
8. If so, to what do you attribute this difference?
9. And is it qualitatively or quantitatively different?
10. How do you see the impact of HIV/AIDS on communities – what manifestations of the problem have you experienced?
11. Do you think people in the villages know about, and understand, HIV/AIDS?
12. Do you think the AIDS awareness campaigns being conducted are effective?
13. If yes, why are they effective?
14. If no, why aren't they effective, and how do you think they could be improved?
15. Do you sense that the government is committed to the fight against HIV/AIDS?
16. Can you give examples which demonstrate how they are/are not committed?
17. What cultural factors are you aware of that contribute to the HIV/AIDS problem?
18. What cultural factors are you aware of that mitigate the AIDS problem?
19. How do you see gender relations interacting with HIV/AIDS?
20. What do you think the role of the schools is in regard to HIV/AIDS?
21. What do you think the role of the churches is in regard to HIV/AIDS?
22. What do you think the role of the hospitals is in regard to HIV/AIDS?
23. What superstitions are you aware of related to HIV/AIDS?
24. Do you think traditional healers have a role to play in the fight against HIV/AIDS?
25. If 'yes', what role do they have to play?
26. If 'no', why don't they have a role to play?
27. What difference do you think it makes to a family if the mother dies as opposed to the father?
28. Do you think there is a stigma attached to being HIV positive?
29. If 'yes' – why do you think there is this stigma?
30. If 'no' – why do you think there isn't a stigma attached?
31. Do you think that AIDS-related deaths are treated any differently from other deaths?
32. Do you think that men and women discuss the problem of HIV/AIDS with each other?
33. If 'no' – why don't they discuss it?
34. What are the differences in burial rites between a man's funeral and a woman's funeral?

HIV Questions

These questions formed the basis of interviews with members of the Limbikani AIDS Support Group.

1. When did you find out you were HIV positive?
2. Why did you go for an HIV test?
3. Did they tell you they were testing for HIV when they did the blood test at the hospital?

4. Do you know how many times they performed the HIV test?
5. How did you become involved with the Limbikani group?
6. What was your reaction when you were told you were HIV positive?
7. Does your family know you are HIV positive?
8. If 'yes' – what was their reaction when you told them?
9. If 'no' – what do you think their reaction would be if you were to tell them?
10. Are you married?
11. Have you discussed your HIV status with your spouse?
12. How many children do you have?
13. How old are your children?
14. Have your children been tested for HIV?
15. Did the people at the hospital discuss the issues of becoming pregnant while being HIV positive with you?
16. Did they discuss issues related to breastfeeding while being HIV positive?
17. Have you made any plans for your children if you get too sick to look after them?
18. Have you asked your relatives or friends to be ready to help you if you are too sick to look after your children?
19. What do you know about HIV and AIDS?
20. What were you told to do about being HIV positive in the hospital?
21. Do you think others in your village have this same knowledge about what HIV/AIDS is?
22. Do you think people are scared about HIV in your village?
23. If 'yes', why are they scared?
24. Do you feel that there is any difference between being infected with HIV/AIDS and any other illness?
25. If 'yes', what kind of difference?
26. What will happen to your house and fields when you die – who will inherit them?

APPENDIX 3: INTERVIEW QUESTIONS IN CHICHEWA

Questions for initial interviews:

1. Kodi banja ndi chiani?
2. Kodi m'banja anthu amapangirana chiani poonetsa kuti ndi amtundu umodzi?
3. Kodi mkadzi amadziwa bwanji kuti ali ndi pakati?
4. Mungandiuzeko miyambo yomwe mkazi amayenera kutsata akakhala ndi pakati?
5. Ndiye akapanga chiwerewere chimene chimachitika ndi chiani?
6. Kodi pali ubale wotani pakati pa mayi ndi kamwana kamene kali m'mimba mwake, mwachitsanzo: kodi kamwanako ndi mbali ya mayi kapena ndi kamunthu nako pakokha?
7. Mwachitsanzo paamwana amene munabeleka pomaliza,kodi panachitika zotani ndi m'mene munaonera inu?
8. Kodi m'mudzi mwanu azimayi amakabelekera kuti?
9. Anthu amene amakhalapo pa nthawi yobelekela ntchito yawo ndi chiani?
10. Amalamula ndi ndani kuti azimayi azikabelekera ku chipatala?
11. Kodi mimba yabwino ndi yiti?
12. Nanga pakati posakhala bwino?
13. Kodi mavuto wokhuzana ndi pakati angadzindikilike bwanji komanso ndi ndani?
14. Nanga mavuto wokhuzana ndi pakati amatha bwanji?
15. Kodi mavuto wokhudzana ndi amayi akabeleka amadiwidwa bwanji komanso ndi ndani?
16. Kodi amayi ndi ndani?
17. Nanga abambo ndi ndani?
18. Kodi makolo amachitirana chiani?
19. Kodi kholo la bwino limapanga chiani?
20. Mukugniza kuti kukhala kholo ndi chinthu chofunika kwa inu?
21. Mukuganiz kuti kukhala kholo ndi chinthu chofunika kwa anthu?
22. Kodi mumakhala ndi kuchita bwanji kuti mukhale kholo la bwino?
23. Kodi mungandifotokozere kuti AIDS ndi chiani?
24. Nanga HIV ndi chiani?
25. Kodi mukudzziwapo munthu amene anamwalira chifukwa cha kachilomboko, koma musanene munthuyo ayi?
26. Kodi mukudziwapo munthu amene ali ndi kachilombo ka HIV?
27. Kodi mukuganiza kuti anthu amene ai ndi kachilombo ka HIV amasamalidwa mosiyana ndi anzawo?
28. Kodi mukuganiza kuti pali kusiyana pakati pa munthu wa mkazi kapena wa mwamuna amene ali ndi kachilombo ka HIV pa chisamalidwe chawo?
29. Kodi munthu wofa ndi matenda a EDZI, kasamalidwe kake kamasiyana ndi munthu wofa ndi matenda ena?
30. Kodi munakayedzetsapo magazi anu kuti muone kuti muli ndi kachilombo?
31. Kodi maliro azimayi amasiyana bwanji ndi maliro azibambo?

32. Kodi chimachitika ndi chiani kwenikweni ndi thupi la mzimayi akamwalira? Zimasiyana bwanji likakhala thupi la mzibabo?
33. Nang m'ene malirowo amasamalidwa, zimasiyana bwanji ndi munthu amene anali kholo?
34. Mungandiuzeko kusiyana kwa imfa ya azimayi kapene azibambo momwe anthu amaonetsera chisoni chawo?
35. Kodi amene amaoneka wokhumudwa kwambiri ndni pa maliro?
36. Kodi chifundo chawo himasiyana akakhala maliro a munthu wa mkazi kaena wa mwamuna/
37. Inuyo m'magnizo anu, kodi njira yabwino yomwalira ndi yiti?
38. Ndipatseni zitsanzo za mavuto amene amaoneka m'banja mtsikana kapena mayi atangowalira kumene?
39. Kodi mukuganiza kuti zaka za ana anu pa nthawi ya maliro a amayi awo kapena achemwali awo panaoneka kusiyana ndi m'mene imfa yinakukhudzilani m'banja?
40. Kodi mukuganiza kuti ndi chinthu chovuta kwambiri kwa ana kuti amayi awo amwalire pamene ali a ang'ono kapena ali wotha msinkhu?
41. Kodi umbiri wa ana amene anasiyidwa ndi amayi awo atangomwalira kumene, akupangitsa kusiyana mbanja?
42. Kodi panali mwambo wina uli wonse wa makolo pa nthawi ya maliro a akazi anu?
43. Kodi ku mbali ya inu ngati bambo yinasinthika chifukwa cha imfa ya akazi anu?
44. Kodi kukhala kwanu pogwiriana ndi anthu kunasinthika chifukwa cha imfa ya akazi anu?
45. Kodi munakwatilanso akazi anu atamwalira?
46. Ndiye mukuganiza zokwatilanso mtsogolo muno
47. Chifukwa chiani inu mukuganiza zokwatilanso?
48. Ndiye mukuganiza kuti mkazi wanu wa tsopanoyo, adzavomera kulera ana a mkazi wanu woyamba?
49. Kodi mumakhulupilira mizimu?
50. Mizimuyo yinasintha moyo wnu mu njraa yina yiliyonse?
51. Ndiye mizimuyo yimakuchitilani chiani?
52. Dzina lanu ndinu andani?
53. Muli ndi zaka zingati?
54. Akazi anu anawalir liti
55. Anamwalira ndi chiani?
56. Kodi mumahala anthu angati m'nyumba mwanu?
57. Ndinu a mtundu wanji?
58. Mumakhala chikamwini kapena kwanu?
59. Ndinu a chipembedzo chanji?
60. Munapunzira kufikila pati?
61. Ndalama mumazipeza kuchokera kuti?

Follow-up interview questions:

1. Kodi azimayi m'mudzi mwanu amapita kwa sing'anga akakhala ndi pakati?
2. Kodi munakawonanapo ndi asing'anga pamene munali ndi pakati? Chifukwa?

3. Kodi munthu akakhala ndi pakati, thupi limathenda? Chifukwa?
4. Kodi chinanso ndi chiani? Chimene chimapangitsa kuti thupi la ...
5. Kodi mazimayi wapakati angapange chiani kuti thupi lake lizikhala losatentha mthawi zonze?
6. Kodi mumadsiwapo sing'anga wina aliyense amene amachidza matenda a AIDS? Ngati ndi choncho, kodi amachidza bwanji?
7. Lkodi mukudziwapo anthu amulungo amene amachidza matenda a AIDS? Ngati ndi choncho amachidza bwanji?
8. Kodi mukuganiza kuti pali kusiyana pakati pa munthu wofa ndi matenda a AIDS kapena Malaria?
9. Kodi momamva bwanji ndi imfa?
10. Kodi mumaganiza za imfa nthawi zonse? Chifukwa Eha chiani mumayiganisa?
11. Kodi mukuganiza kuti chinthu chofunika kwambiri chimene ndichosiyana pakati pa amayi ndi abambo ndi chiani?
12. Kodi abambo ndi akazi awo, amakwambirana za pakati?
13. Kodi mumaganiza bwanji ana amene munthu kukhala nawo? Kodi ndi ndani amapanga zimenezi?
14. Kodi munamvapo zotani za kulera? Kodi munagurin'tsapo ntchito njira ymeneyi kapena mumagurintsa nchito njire yimeneyi nthawi zonse?
15. Kodi mumaganiza bwanji. Za chishango?
16. Kodi mtsikana amakhala bwanji mayi?
17. Kodi mnyamata amakhala bwanji bambo?
18. Kodi mumakhulupilira mizimu? Ngati ndi choneho, mizimu yake yotani?
19. Kodi mizimu yimasintha moyo wano m'njira yiliyonse? Ngati ndi choncho, bwanji?
20. Kodi mungapito kwa mizimu kuti yikuthandizeni? Ngati ndi choncho, mumakapanga bwanji?
21. Kodi azimayi amafunika kuti akwatire kaye asanatonge pakati? Ngati ndi choncho, ndi chifukwa chiani mumafuna kuti akwatire?
22. Kodu munafuna kuti amuna akwatire kaye mpamene ana aziwayitana abambo?
23. Kodi atsikana amakwatire ndi msinkhu wotani? Nanga anyamata?
24. Kodi pali sifukwa zina zimene makolo amawadyetsera anu kupaturako kudwala (malnutrition)?
25. Kodi muneysitake ku maliro ambiri?
26. Kodi mukamapita ku maliro, mumamva bwanji?
27. Ndinawona kuti ana a ang'ono akakamira kwambiri azichemali kapenanso azikulu awo, kodi chimenechi ndichofunika? Mundifotokozere chifukwa zimenezi zimapangika. Kodi zimenezi ndi zoona kuti zimapangika m;mbanja m'mene amoyi amwalira?
28. Amayi atangomwalira kumene, kodi mumsankhu bwanji kuti awa ndi amene aziwonera ana?
29. Ndina'ona mmabanja amene amayi anamwalira komanso mabanja amene abambo anamwalira ngakhalenso m'mabanja m'mene abambo ndi moyo koma amawasiya ana akde. Kodi mukuganiza kuti zimenezi zimapangika chifukwa cha chiani?

30. Kodi mukuganiza kuti AIDS indi chinthu choopsa kwambiri ke dera lanu? Chifukwa?
31. Kodi mukuganiza kofi AIDS ndi chinthu choopsa ku banja lanu? Chifukwa?
32. Kodi mukuganiza kutichinthu chimene ndi vuto kwambiri ku dere lane ndi chiani?
33. Kodi mukoganiza kuti mavuto amene ndivovota kwambiri a thupi ndi chiani ku dera lanu?
34. Kodi mapaganiza bwanji kuti uku ndi kumene akayikidwe munthu? Kodi amanene ndani?

HIV interview questions:

1. Munaadziwa liti kuti muli ndi kachilombo?
2. Ndiye mutafika kuchipatala anakuuzani kuti akufuna kuti aone ngatimuli ndi kachilombo?
3. Munakhala bwanji m'modzi mwa Limbikani AIDS Group?
4. Ndiye atakuuzani muli ndi kachilombo, munachita chani ?
5. Ndiye panopo m'mene mukudziwira kuti muli ndi kachilombo, mukumva bwanji kapena mukupanga chiyani?
6. Anthu kubanja kwanu kuno akudziwa kuti muli ndi kachilombo?
7. Ndiye mutawauza kuti muli ndi kachilombo, anapanga chiyani?
8. Anthu m'mudzi mwanu akudziwa kuti muli ndi kachilombo?
9. Ndiye mukuganiza kuti angachite chiani inuyo mutawauza?
10. Kodi mukuganiza zokwatiranso?
11. Amuna anu anamwalira liti?
12. Amuna anuanapita kukayezetsa magazi?
13. Anamwalira ndi chiani?
14. Muli ndi ana angati?
15. Ali ndi zaka zingati?
16. Ana munakawayezetsa magazi kuti muone kuti ali ndi kachilimbo?
17. Akadalibe kuyamwa?
18. Amene adzakuonereni ana ndi ndani mukadzadwala?
19. Ndiye munawauza?
20. Mukudziwapo chiani za HIV ndi AIDS?
21. Munthu wina aliyense anakuuzaniponi zotenga pakati muli ndi kachilombo?
22. Ndiye mukuganiza zotenga pakati?
23. Kodi mukuganiza kuti anthu m'mudzi mwanu akudziwa za HIV ndi AIDS?
24. Mukuganiza kuti akuwopa kutenga kachilombo?
25. Kodi mukuganiza kuti pali kusiyana kuti munthu adwale AIDS ndi mwina malungo?
26. Mukuganiza kuti anthu amene ali ndi kachilombo, amasamalidwa mosiyana ndi anzawo.

APPENDIX 4: INTERVIEW RESPONDENTS

The following appendix presents a table that indicates the names of all informants, along with their place of residence, and age. It further categorizes the nature of my relationship with each informant, using the categories of 'general informant', 'in-depth contact', 'basic case-study', 'HIV informant' and 'key informant'.

A 'general informant' is a person who did not necessarily meet my criteria for inclusion as a case study, but who provided me with general information about Malawian culture, and commented on the process and results of my research. Such people include Joe Nyirenda, the older brother of my research assistant Fadi, who helped significantly with the development and translation of interviews and who would also provide further clarification and/or confirmation of information received elsewhere. His wife, Brenda, also helped significantly especially since she, too, as an expatriate, had experienced many of the difficulties I was faced with.

The category of 'in-depth contact' refers to an individual whom I got to know very well, through interviews and repeated visits to the person's house. These individuals were seldom pre-selected, rather willingness to cooperate and ease of access combined to enable me to get to know these families in detail. In one instance however, that of Gladys, the individual was specifically chosen for more in-depth research because she was an elderly grandmother caring for orphans, and someone with whom I could easily make contact. The other grandmother among the interview respondents from Songani or Galamadzi with whom I initially had frequent contact, is Eunice but, unfortunately, her husband died soon after my first interview with her, and because of the added stress this placed on her, and her increased involvement with a local church group, I was unable to see her very often, hence she remains in the 'basic case-study' category. I later met Edith Moses, another grandmother caring for orphans, and she is also included as an in-depth contact. While Mai Chauluka and Mai Chauwa are also both grandmothers, I interviewed them on their arrival at Open Arms (OA) to collect the orphaned infants who were residing in the home. Since neither would be returning to OA, and they both lived far away from Zomba, there was no further opportunity to familiarise myself with their stories. There is anecdotal evidence to suggest that the incidence of grandparents as primary caregivers is increasing in Malawi though, currently, the majority of caregivers are the sisters of the deceased mother, and as such I made the effort to include Gladys and Patricia as in-depth case-studies to ensure some representation of the 'grandmother as primary caregiver' category.

Those individuals classified as 'basic case-study' are people with whom I had less contact compared with those from the 'in-depth study' category. Some individuals were only interviewed once, with little further follow-up contact. This is true, for example, of many of the young orphans such as Antonio, Edward and Magret, since the children were generally more difficult to get hold of during the day. Occasionally they were in school, but more often they were playing in the fields with friends and couldn't be found. Furthermore, the children were not forthcoming in interview

situations, finding the experience somewhat intimidating. Casual discussions with children when we met outside of the interview context were more fruitful in terms of data collection. Older orphans such as Ignazio and Khomeini are included in the 'in-depth study' category since I was able to interview them more often, as well as meeting them informally on multiple occasions.

'HIV informants' are from the Limbikani AIDS Support Group (LASG), and answered questions related to living with HIV. They are unnamed since few of them had admitted their status to their families, so their status is not public knowledge.

Mr Mpoya and Philip are classified as 'key informants', since not only were they gatekeepers to their respective communities (Songani and Galamadzi), but they were also a resource for confirming my results from the field and the emerging theories. Philip was also providing assistance for his sister's orphans, so in addition to being a research assistant was also a case-study.

Very few adults were sure of their ages, there are therefore many blanks in the 'age' column. The children all had an idea of how old they were and their ages are included. Generally, those respondents who have no indicated age fall between their thirties and sixties.

Name	Residence	Age	Category of informant
Antonio	Galamadzi		Basic case-study
Balala	Galamadzi	19	Basic case-study
Beatrice	Galamadzi		General informant
Daban	Galamadzi	14	Basic case-study
Daina	Galamadzi	44	Basic case-study
Damiano	Galamadzi	40	In-depth contact
Davis	Galamadzi	12	Basic case-study
Dora	Galamadzi		In-depth contact
Eunice	Galamadzi		Basic case-study
Grace	Galamadzi		In-depth contact
Henry	Galamadzi		General informant
Ignazio	Galamadzi	24	In-depth contact
Irene	Galamadzi	12	Basic case-study
Khomeini	Galamadzi	9	In-depth contact
Lonnie	Galamadzi		Basic case-study
Mai Kambala	Galamadzi		General informant
Mai Matthews	Galamadzi		In-depth contact
Majawa	Galamadzi	5	Basic case-study
Malita	Galamadzi		Basic case-study
Pastor Simbowe	Galamadzi		General informant
Patricia C.	Galamadzi		In-depth contact
Philip	Galamadzi		Key informant
Thandizani	Galamadzi	16	Basic case-study
LASG 1	Limbikani		HIV informant
LASG 2	Limbikani		HIV informant
LASG 3	Limbikani		HIV informant

LASG 4	Limbikani		HIV informant
LASG 5	Limbikani		HIV informant
LASG 6	Limbikani		HIV informant
Aleki	OA		Basic case-study
Delex	OA	39	Basic case-study
Mai Chauluka	OA		Basic case-study
Mai Chauwa	OA		Basic case-study
Mai Eunice	OA		Basic case-study
Rosemary	OA		General informant
Bessy	Songani		General informant
Catherine	Songani	41	In-depth contact
Edison	Songani	22	In-depth contact
Edith Moses	Songani		In-depth contact
Edward	Songani	14	Basic case-study
Ellen	Songani		In-depth contact
Enlock	Songani	18	Basic case-study
Feria	Songani		Basic case-study
Fidelia	Songani		Basic case-study
Frank	Songani		Basic case-study
Gladys	Songani		In-depth contact
Linly	Songani		In-depth contact
Magret	Songani	12	Basic case-study
Mai Evans	Songani		Basic case-study
Mai Koloko	Songani		Basic case-study
Mai Sani	Songani		Basic case-study
Margaret	Songani		In-depth contact
Mebo	Songani		Basic case-study
Mr Mpoya	Songani		Key informant
Patricia H.	Songani		Basic case-study
Tereza	Songani		In-depth contact
Stella	Songani		In-depth contact
Brenda	Zomba		General informant
Joe	Zomba		General informant
Cathy	Zomba		General informant
Lovemore	Zomba		In-depth contact
Mai Edwin	Zomba		In-depth contact
Marcus	Zomba	32	In-depth contact
Monica	Zomba	7	In-depth contact
Mr Nkhoma	Zomba		Basic case-study
Mrs Namona	Zomba		General informant
Ned Lawton	Zomba		General informant
Nora	Zomba		General informant
Regina	Zomba	12	In-depth contact
Samuel	Zomba	50	Basic case-study
Steve	Zomba		Basic case-study

APPENDIX 5: CABA FORUM DISCUSSION 'WASHINGTONPOST.COM: A GENERATION ORPHANED BY AIDS'

At 11:28 AM 8/13/2003 -0400, Janet Feldman wrote:
APOLOGIES FOR CROSS-POSTINGS washingtonpost.com
A Generation Orphaned by AIDS Kenyan Children Struggle to Survive as Relatives Shun Them or Take Advantage
By Emily Wax
Washington Post Foreign Service
Wednesday, August 13, 2003; Page A01

EAST KAGAN, Kenya -- In the dry fields of their village, Beatrice Nanjala showed her 9-year-old daughter Lily how to harvest maize and sorghum. She instructed Lily, a thin girl with arms as willowy as the stalks in the fields, to use both hands to lift the bulky wooden farming tool and pound the cluster of dense flowers into seeds.

She taught Lily how to build and repair mud huts. They fetched water from about two miles away. They poured it into chunks of dirt. They churned. Slowly, her mother packed the hulking mounds of mud onto the roof and walls.

Then, one day two months ago, when Nanjala's knees were weak, when her stomach was swirling and her body feverish with AIDS, she showed Lily her last lesson: how to dig a grave. Lily had seen her mother do it before. Lily's father, John, a police officer, died of complications of the disease and was buried on a cold day in August 2001.

With the help of Lily's brothers, Phelix, 16, and Clinton, 7, they scooped the dirt out of the red earth before sunset.

The siblings buried their mother a week later.

Their sister Mary, just 17 months old and HIV-positive, sat in the dirt and grass watching as they made a grave for a mother she would never know.

Lily and her siblings are part of the lost generation. More than 3.5 million children across sub-Saharan Africa have lost both parents to AIDS, according to the U.N. AIDS organisation, and more than 13 million have lost at least one.

Children are already going hungry because parents who were farmers are dead.

'Economies are collapsing and famines are growing in areas that always had food,' said Aloys Nyabola Mbori, who leads a committee to find ways to feed and care for the swelling number of orphans in East Kagan, a village in western Kenya that is a

day's drive from Nairobi, the capital. 'Africa has seen poverty, but this will be worse than anything we have ever known.'

Families are breaking apart because they cannot feed all of the orphaned relatives who come to the door, desperate for help.

'Relatives have too much in their mouths to chew,' said Gideon Oswago, the head public health officer for the African Medical and Research Foundation, an organisation based in Nairobi. Oswago cares for four orphans, along with six of his own children. 'It's reached the point where if you see an orphan coming, it's a huge burden,' he said.

There is also concern among health and education workers that a generation growing up without parental guidance will worsen political instability on a continent already struggling to overcome terrorism and civil and ethnic strife. Rebel groups have tapped into the vulnerable orphan populations by enticing abandoned children to earn money, food and respect with guns -- leading to more chaos and increasing the chances of rape and HIV transmission.

'The implications of this are monstrous. The profound trauma of losing a mother or both parents has devastating long-term implications, not only for a child's well-being and development, but for the stability of communities and, ultimately, nations themselves,' said Carol Bellamy, executive director of the U.N. Children's Fund. 'Children and women caught up in the chaos and forced displacement of war are more vulnerable to sexual abuse and exploitation, which facilitates the spread of HIV.

In Nairobi, orphaned boys wander the streets barefoot and dirty, many sniffing glue. Crusted white layers are stuck to their nostrils. They are known across the continent as 'glue boys,' and some fall into committing petty crimes like stealing cell phones and wallets, aid workers report, mostly because they have no other way to survive.

When the disease first came to East Kagan, it was called 'the slim,' meaning a curse causing dramatic weight loss. But now, as the population of orphans has ballooned, the villagers and many like them across East Africa call the AIDS pandemic 'the disaster.'

A Grave for Mary

Lily followed the lessons her mother had taught her before she died with the discipline that she once used to copy the alphabet into her notebook at school.

But a week after her mother's death, Lily stopped going to classes. She had to care for young Mary, who was suffering from blotchy skin rashes, fevers and constant vomiting.

The next month, Lily and her brothers, who do not have HIV, dug a grave for little Mary. She died on a cloudy afternoon.

'I was sad. I couldn't stop crying,' mumbled Lily one recent day, as she pounded mud and smeared the cracks in their hut. Lily was left in charge of the house when Phelix traveled 15 miles to the nearest town, Homa Bay, to work in a shack restaurant.

On this day, she woke before the sun rose. She scrambled off of her foam mattress. In the cold morning air, she walked in a long shredded T-shirt to the water pump and balanced an eight-pound jug atop her head. She went to the fields. She picked sorghum. She tried to pound the buds into seeds. It was like watching a toddler try to wield a hammer.

In the afternoon, a Kenyan nurse, Helen Kelly, known here as Mama Kelly, came for a visit. She works with the research foundation, and she travels several hours every day on a cratered road to help orphans with counseling, school fees and health care.

'Slowly, slowly,' Kelly said gently in Swahili to Lily. 'Lily is such a good girl.' She smoothed her hand over Lily's back and then walked away. She folded into tears.

'What is happening to Africa?' she lamented. 'The next Nelson Mandela could be here and we would never know, we would never see the orphans reach their potential.'

Strained Family Ties

In East Kagan, a sprawling village of 3,000, one in every three people has the disease and there are more than 400 orphans, many struggling to survive on their own. Tucked into a trail of knobby grass and mud footpaths, the village is made up largely of the Luo tribe, the second-biggest ethnic group in Kenya.

The village is in one of Kenya's poorest districts. Mud huts with thatched roofs sit in clusters of three or four in the scrappy, flat fields. Small sprouts of wilting maize cover fields that are gray and dry from the hot sun and lack of rain

A few men herd cattle. A few children lead donkeys to carry water and firewood. Like many rural communities in Africa, the village has no cars, no electricity and no running water.

Parents who are dying of AIDS linger at the village's one-room health clinic, looking weak and begging for aspirin to ease their pain. No one here can afford the life-saving drugs available in the West.

Parents are dying so quickly that they don't have time to ask relatives if they can take in their children. Fights have broken out in the village over which family will care for which orphans.

Children run around barefoot, kicking balls made from plastic bags and rubber bands. The mzees -- Swahili for elders -- walk with sticks through the village with creased faces and hunched bodies.

The lack of a middle generation is startling. Small dirt mounds -- graves of parents -- can be seen on the grounds of huts throughout the village. Lily's neighbours are orphans, too. And they seem even more baffled by their new situation.

The eldest of the neighbouring family is Castrol Videli Omondei. He is 13. He stands perfectly straight, even as his ribs protrude from his chest. He cares for his sister, Molly, who is 11. She nursed her mother when she was sick and now seems haunted by the experience.

Molly wears a torn pink shirt and a blue skirt and rarely smiles.

Her uncle, John Okuoga Niyare, has offered to help, but admits that he gives priority to his own children.

He stuffs Molly and Castrol into his overcrowded hut when they are afraid to sleep alone.

Recently, he has been so low on cash that he has started farming their land, too, and taking the crops.

At lunch, Molly gets only groundnuts, while her cousin dines on fish. She stares at her cousin's plate but becomes so frustrated that she leaves the hut.

'I am ashamed, but it's true,' Niyare said, lowering his eyes. 'We are trying. I just don't know what to do.'

Other orphans have family members who have completely abandoned them, a phenomenon that was unusual in Africa before AIDS.

Lily has an aunt. But the last time she saw her was at Mary's funeral. The aunt then took away another brother, Mark, 12, to do farm work because he appeared the strongest.

She hasn't been back since. She already has four children of her own, plus five orphans from her husband's side of the family.

A Feast of Burden

In the Luo culture, there is no bigger event than a funeral feast. To honor the life of the dead, relatives, friends and just hungry people often travel long distances to attend.

The funerals are often larger than weddings and involve an ample feast, at the expense of the family's few animals and meager savings. The tradition has become a

new burden for AIDS orphans: When the relatives and friends go home, the orphans are left with nothing to eat.

In Africa, where a cow or a flock of chickens is as good as money in the bank, they are left with nothing to sell. They don't even have eggs or milk after their animals are killed.

In the case of Castrol and Molly, the feasting began as soon as their mother's body was put into the earth. First, three cows were slaughtered. Then, relatives killed 20 chickens and four rams. The children's mother, Helon Akoth, had requested that such an expensive ceremony be delayed. Their father was also dying, and she wanted her children to save money.

But no one listened.

Instead, relatives feasted on the roasted meats along with plates of sukumawki, or boiled green leaves, hunks of ugali, or mashed maize, and stacks of chapatti bread, as well as rice, mangoes, pineapples and sweet potatoes. To drink, there was a very expensive treat: creamy cups of thick ground nuts blended with lime and milk, forming a thick shake. Local alcoholic brews also flowed.

Almost everyone at Akoth's October funeral ate until their bellies hurt, even those who work in Nairobi and rarely feel the kind of bone hunger that rural villagers experience.

But Castrol and Molly didn't feast.

Instead they watched their father, Issaiah Lieta, who was asleep, exhausted from his latest bout with diarrhea, a side effect of AIDS.

'I was worried about money, and the animals were all being eaten,' Castrol recalled. The feast cost the equivalent of $300, about what the family makes in a year.

His father, 40 and a welder, died the next month. A second feast was planned, this time with the remaining cow and dozen chickens. In the end, Mama Kelly recalled, nearly two years' worth of food and money for school uniforms and books was lost.

The orphans are left now with one bag of groundnuts. Molly is literally starving and complains to her teachers of headaches.

A similar chain of funerals and feasts happened in Lily's family. She has taken to eating grass.

Home Is an Empty Hut

After the funerals, Castrol and Molly decided to redecorate their dark, one-room hut. He handed white chalk to Molly. She drew on the clay-colored walls for hours.

It was a playful act. And it was something they were not allowed to do when their parents were alive.

They sketched pictures of flowers and math problems from textbooks and phrases from Bible workbooks to keep them company.

'Where is Jesus?' one chalked statement in young handwriting asks. 'Where is the land of Canaan?' another pleads.

The hut is empty. Their uncle admits that he took all of their furniture, including their foam mattresses.

He said he is keeping the furniture to protect it from being stolen. In some African tribes, the brother of the husband inherits everything when the male head of a household dies. Land. Cows. Small farms. Sometimes, even the wife is inherited for marriage.

For orphans, keeping their land is the key to avoiding a life of begging, crime or prostitution on the streets, and ensures a minimum level of health, Kelly said.

Inside the village health post, a nurse reports increasing cases of malaria, scabies, bronchitis, lice, sexual disease and early pregnancy in girls as young as 12 after parents die and food and shelter disappear.

A law passed in 1981 in Kenya allows children to inherit their parents' property. They can use lawyers to reclaim anything that has been taken away. But in rural areas, people do not know they can bring cases to court.

Phelix was so worried about distant relatives coming and taking their property that he took a job at the Star Light Hotel, the dank restaurant in Homa Bay. He earns less than 20 cents a day and tries to save as much as he can in case his family is forced to move. Some friends in the town have turned to sex with men to earn their daily bread. Others leave for Nairobi. Sometimes Phelix feels overwhelmed and wants to leave and learn a trade. But he stays, helping in the fields when he can.

'If I left, what would they eat? I can't leave them,' he explained, softly. Then he looked down and said: 'I am too proud of Lily and Clinton. I love them.'

Going to School Hungry

Molly grabbed a photo of her mother on a recent day and headed off to school. She keeps it in her pocket. She has decided to keep showing up at Opinde Primary School, about a 45-minute walk away, even though she has no shoes, no breakfast and no uniform.

The lack of a uniform irks her the most. Her friends all have dark blue dresses and even cute red, blue and orange yarn school bags. She carries her notebook in a plastic bag.

'I am feeling really bad,' she said as she trudged off to school. 'I don't look smart.'

But what bothers her teachers is something far more basic: food. Free primary education began this year across Kenya, but lunch remains a dream.

Sitting inside a room with chipped paint on the walls, Charles Otieno, the headmaster, reports that 100 students out of 400 in his school are orphans, and this has made learning almost impossible.

He said that after Molly's mother died, she stopped cleaning herself. Her grades fell. She stopped talking in class and hides in a corner as others sing and play in the courtyard. A teacher comes by and tells Molly that she is very brave and will be okay. Molly just frowns and turns away. She has started missing school.

When Castrol shows up, he falls asleep. Before his parents died, he was at the top of his class.

'It's sad and very common,' Otieno told teachers gathered for a meeting about the growing number of orphaned students.

The school has started more lessons on farming, so that orphans can at least grow their own food.

Otieno is also considering teaching personal hygiene. And maybe hanging up photos of the parents would be a good idea, he said, because he could use them to help orphans cope with memories.

Either way, he needs a way to bring the students back to class.

Phelix, Lily and Clinton don't show up at school anymore. They are all too busy in the fields.

>CABA Forum wrote:
>Dear all
>It is good that the Washington Post article, 'A Generation Orphaned by AIDS,' conveyed information about the horrific human costs of AIDS. What troubles me, though, about this kind of article, of which there have been many in the US media, gives and incomplete and therefore distorted picture of the situation. Consequently, this kind of story can encourage inappropriate action or, because the situation seems so hopeless, no action at all.
>The impression that many (I suspect most) Americans have about AIDS and orphaning in Africa is that most of the adults in the prime years for work and child-rearing are dead or dying. Surviving Africans, faced with the scourge or HIV/AIDS, are seen has being helpless, unable to help themselves or the children and elderly

who are left to cope on their own. What this article does not convey, nor have I seen others present, is the heroic efforts I've been privileged to see, where people (most of them poor) come together in villages and urban communities to do what they can to help children and adults worse off than themselves. Such people and extended families are the first line of response to HIV/AIDS, and what is done by governments, NGOs, religious groups, international organisations, donor agencies, and others will make significant impact in the long term only if it supports and strengthens the ongoing, daily efforts at family and community level.

>The truth is that there is great capacity in Africa and the situation is not hopeless. Most adults, even in the countries with the highest HIV prevalence, are HIV negative. Most of the people who are HIV positive are healthy and able to work during most of the time that they are living with HIV. The large majority of orphans in Africa live with a surviving parent or within their extended family and communities (albeit often with great hardship), and it is probably a very small minority who have slipped through these primary social safety nets and end up on the street, in villages without any support or in orphanages.

>But this is not the impression that most American have. Consequently, many, if they do not just shake their heads and turn away, assume that the only constructive approach is to build orphanages or new villages for the survivors. For many reasons, building more such institutions is not a good idea. The money it consumes (from about $500 per year per child in some African countries, much more in others) could help many more children stay in families if it were used to strengthen the capacity of families and communities. The costs of keeping one child in an orphanage could enable six or more to live with a family in their own community.

>Also, the long term developmental consequences of growing up in an orphanage or children's village tend to be negative. Children who are not able to form the kinds of attachment with an adult, which necessary to fulfill their basic human need for connection, can have lifelong difficulty trusting people and maintaining relationships. Cut off from normal cultural opportunities, they may not learn how to behave and do the things that people normally do with the society. If you have ever visited an orphanage where small children came up to you wanting to hold your hand, you've seen a symptom of children with an attachment deficit. The normal response for young children is to be wary of a stranger.

>Another problem with building new orphanages is that they become a very expensive and inefficient way to fight poverty. The more places that are created in orphanages or children's villages in areas under severe economic stress, the more children are likely to be pushed out of households to fill them, because someone else is willing to assume responsibility for providing a roof and food. Building more orphanages begins a never ending cycle.

>By the time they reach adulthood some children raised in an institution have become, not by their own choice, professional orphans who have learned by what they have lived that someone else must be responsible to provide for all their basic needs. They may not have the connections to an extended family that forms the primary social safety net for most adults in time of need. Some even lose the ability to speak their mother tongue.

>There are better alternatives for the children whose own families fail them. Foster family care, a which is more like adoption than it is like foster care in The United States, has been shown to work in Africa. The major problem is that these

programmes are severely under-resourced. Local adoption can also work if the resources are provided to develop it. Some organisations have developed and supported family-type groups integrated in communities. Some local orphanages have recognised that they cannot accommodate an increasing number of orphans and have begun to provide day support or outreach support to orphans and other vulnerable children living with families. Also, with support, teens sometimes prefer to live on their own in small groups if they can be given some support and training as they learn how to live on their own. Child-headed households may benefit from support from extended family members, neighbours, and NGOs. Institutional care is not the only alternative to the street if children are without family care, but these other approaches need to be greatly expanded. Resources are needed to do that.
>The primary responses that should be supported are those that will help children to remain within their families and communities. The five strategies from Children on the Brink 2002 (USAID, UNICEF, and UNAIDS -- http://www.usaid.gov/pop_health/aids/Publications/docs/childrenbrink.pdf) provide a basic framework for what need to be done to keep the number of children without family care to an absolute minimum:
>1. Strengthen and support the capacity of families to protect and care for their children.
>2. Mobilize and strengthen community-based responses.
>3. Strengthen the capacity of children and young people to meet their own needs.
>4. Ensure that governments develop appropriate policies, including legal and programmatic frameworks, as well as essential services for the most vulnerable children.
>5. Raise awareness within societies to create an environment that enables support for children affected by HIV/AIDS.
>Action in these areas need support. These strategies reflect the fact that there is capacity and hope in Africa. This is a message that needs to be conveyed along with the images of intense human suffering that the pandemic is causing.
>John Williamson
>Senior Technical Advisor
>Displaced Children and Orphans Fund or USAID

>>From: CABA Forum
>>Reply-To: TvT Synergy Project
>>To: CABA@LIST.S-3.COM
>>Subject: Washingtonpost.com: A Generation Orphaned by AIDS
>>Date: Tue, 19 Aug 2003 18:08:02 -0400
>>Dear All, I read the news from the Washington Post Article about A generation orphaned by AIDS and the reaction of Mr. Williams of USAID. I think Mr. Williams needs to rethink the context the article is addressing. The rate at which children are becoming orphans due to HIV/AIDS related diseases outwieghs any current intervention by any known government to deal with the increasing situation. We know that some efforts are done here and there for some of these childre (in fact a very few of them) but the issue is that the future of African children is at stake with no adult guidance to provide direction. In most communities where AIDS orphans are sheltered and cared for, this is provided by grandparents who themselves are

helpless in thier very old age. Can't we see that there is now a need to rise to this socio-economic dilema hanging over the african children's future in generations to come?
>>Please policy makers should see the issues and needs of AIDS orphans as timely agenda to give due and adequate attention to now with full force or their destiny will judge all of us for now actiting in good time to give them a hope and a future.
>>Thanks to all who care and will act in the same speed.
>>Joshua Ida Samson
>>Management Consultant and President
>>Ohioma Foundation for Development (working to give AIDS orphans a hope and a future

>>>From: CABA Forum
>>>Reply-To: TvT Synergy Project
>>>To: CABA@LIST.S-3.COM
>>>Subject: Washingtonpost.com: A Generation Orphaned by AIDS
>>>Dear all,
I am writing in response to Joshua Ida Samson's response to John Williamson's posting on the Washington Post article. John Williamson (and the follow up from Sonja Giese) does point out a very important problem that we have in the 'developed' nations, that the media will only report what is bad about Africa, highlighting the problems, ignoring the successes. I think it is Mr Samson who should rethink the context here.
Yes, many communities and families face great difficulty coping with high numbers of orphans.
Yes, it is good that articles, such as the one in the Washington Post, highlight this and make the rest of the world aware.
But, and I think this is the main point of John's posting, this gives the impression that extended family networks and communities are failing, and that an alternative (ususally orphanages) must be sought. Consequently, institutional care proliferates, when support to impacted communities and families would provide a much better standard of care, and would be much better able to cope with high rates of orphaning. As Mr Samson rightly points out, efforts exist here and there, but are by no means sufficient. A tendency of resorting to institutional methods may well be at the heart of this.
Families need support, not alternatives. If reportage on the AIDS orphan crisis would point out some simple facts - that the majority of adults are surviving, that projects focusing on community support have had many successes, that the root of the problem is prevailing poverty - then more funds and greater direction may be made available to scale up proven working methods to support these children. Instead people in the west are reading that Africa is full of children with no adults left at all, and are inspired to establish orphanages; an approach that would cost many, many, billions of dollars if all children in need were cared for in this manner.
Neil Monk,
OVC Adviser, FXB Worldwide