University of Applied Sciences
VAN HALL LARENSTEIN
PART OF WAGENINGEN UR

Affected household livelihoods in the wake of HIV and AIDS in rural Namibia
(Case of Odibo village, Ohangwena region)

By
Johanna Mbandi
September 2011

A Research thesis Submitted to
Larenstein University of Professional Education
in Partial Fulfilment of the Requirements for the Degree of Master of Development,
Specialization: Rural Development and HIV/AIDS

Wageningen
The Netherlands

Permission to Use

In presenting this research project in partial fulfillment of the requirements for postgraduate degree, I agree that the library of this University may make it freely available for inspection. I further agree that permission for copying of this research project in any manner, in a whole or in part, for scholarly purposes may be granted by Larenstein Director of Research. It is understood that any copying or publication or use of this research project or parts thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and to the University in any scholarly use which may be made of any material in my research project. Requests for permission to copy or make other use of material in this research project in whole or part should be addressed to:

Director of Research
Larenstein University of Applied Sciences
Droevendaalsesteeg 2 (Forum Building 102)
P.O. Box: 411
6700 AK Wageningen
The Netherlands

Acknowledgements

I would like to acknowledge and thank the Almighty God for all the blessings and protection during my study. This research thesis would not have been possible without the funding provided by the Dutch Government through NUFFIC fellowship (Netherlands) and I would like to thank them for availing funding for me to study the MA programme. I would like to thank Dr Adnan Koucher, my Supervisor of the Van Hall Larenstein University for constant guidance, advice and editing of this thesis.

My sincere appreciation to the RDA course coordinator Ms Koos Kingma, for support and her teaching that enable me to understand concepts of Rural Development in the context of HIV/AIDS during the course

A big thank you to Mr. Michael Conteh and Dr. David Littlewood, for their motivation, guidance, reading and editing my work throughout my study, much appreciated. Thank you to Mr. Jesaya Nakanyala for assisting with SPSS and entire staff of Multidisciplinary Research Centre (MRC) of the University of Namibia, for constant emails and printing my questionnaires.

Thank you to the Omwenetumenge Home Base Care Coordinator Pelitha Haihambo who freely shared information with me on different aspects of the area. The Home Base Care volunteers (Leena Kambunga, Ruth Nakashole, Julia Hanghome and Loide Kashilodi) who helped to inform their communities about my presence and took me to households, they contributed to the high quality of data collected during field data collection. Special thanks to the respondents who participated in this research for availing some of their time in their busy schedules to participate in the survey. Thank you also to those households who spared some of their time to participate in the interviews. I am grateful for this gesture showed by the community.

The hard work, commitment and flexibility of my sister Gayle Shitumbuleni and Queen Namundjebo during the fieldwork is highly appreciated. Lastly thank you to my entire family and friends for their support and prayers during my period of study.

GOD BLESS YOU ALL

Dedication

I dedicate this thesis work to my late mother Tresia Mwadhinomo Ipawa Namundjebo, my Dad Jakes Jacob Mbandi, my entire family, friends and lastly to all those affected and infected by HIV and AIDS.

Table of Contents

List of figures

List of tables

Maps

Acronyms

AIDS -	Acquired Immune Deficiency Syndrome
ART-	Antiretroviral treatment
ARV-	Antiretroviral
ASS-	Annual Agricultural Surveys
CBS-	Central Bureau of Statistics
FHH-	Female Headed Household
HH-	Head of the Household
HIV -	Human Immune Deficiency Virus
MHH-	Male Headed Household
MOHSS-	Ministry of Health and Social Services
NDPs-	National Development Programmes
NPC-	National Planning Commission
PMTCT-	Prevention from Mother to Child Transmission
SLF-	Sustainable Livelihood Framework
UNAIDS-	United Nation
UNAM-	University of Namibia
VCT-	Voluntary Counselling and Testing

Abstract

HIV/AIDS epidemic continue to ravage countries all around Southern Africa, with Namibia being most affected. The current HIV prevalence in Namibia is 18.8%, with more adult between the ages of 15 to 59 HIV infected. With the deepening of HIV/AIDS in Namibia, the household livelihoods in rural areas have been severely affected. Increasing the number of orphans, numbers of deaths and illness in households have also increased. As result draining household resources living them vulnerable to hunger and starvation. This study aimed at identifying the main livelihoods of male and female headed households affected by AIDS within Odibo village of Oshikango constituency. More specifically intended to analyze changes in the livelihood of male and female headed households affected by AIDS and also examine the local supports available for affected households.

A sample of 20 questionnaires was administered to 11 female headed households and 9 male headed households. About four case studies with in-depth interview, purposely selected from the survey of two female headed households and two female headed households were interviewed. The study also interview four key informants, the health worker, home based care coordinator and two volunteers in the village. The data was analyse through SPSS.
The results showed that many of the households were headed by elderly people; this shows a high dependency ratio in the study area. All interviewed households are engaging in cultivation of crops as their main livelihood, with pension and orphan foster grant the three most important livelihoods of the affected households. Other livelihood activities are income generating activities, harvesting of natural resources and few households engaging in livestock keeping. The study reveals that most of the households care for orphans, with female headed household reported to have more orphans than male headed households. Households reported to spent more of their money on food, followed by school fees and transport, less money reported to been spent on medication because Namibia government provide free medication for all HIV infected people and elderly above the age of 60.

Most of the households reported a change in their livelihood as result of illness/deaths related to HIV/AIDS. However, most of the households also indicated that mortality and morbidity as result of AIDS are compounded by the climate change such as floods had destroyed crops, contributing to increased poverty and food insecurity in the households. From the results it is evident that the social capital plays a major role as in supporting households affected by HIV/AIDS. Therefore this study recommends short term interventions for affected households; strengthening of home base care and strategies that provides for income generating activities to reduce poverty among the HIV/AIDS affected households.

Chapter one

Introduction

This introductory chapter gives an overview of the HIV/AIDS in the, Sub-Sahara Africa, Namibia and the study area. The second section of this chapter discusses the problem statement, research objective and research questions. Lastly, the limitations of the study are highlighted.

1.1 HIV epidemic situation in sub-Sahara Africa

In the 1970s no one was aware of HIV it was not until the 80s when the first case of HIV was discovered. Since then the global HIV epidemic has become one of the greatest threats to human health and development. Currently a global estimate of people living with HIV in 2010 is estimated to be 33.3 million (UNAIDS, 2010). Amongst persons living with HIV in the world, 22.5 million live in sub-Sahara Africa. Amongst those that are HIV positive worldwide, the majority are reported to be women with an estimate of 15.9 million, which is over half of the total of people living with HIV in the world. In this report it is estimated that 2.6 million of these HIV positive people are newly infected, (UNAIDS, 2010). The HIV pandemic threatens development efforts globally and hinders the achievement of international agreements such as the Millennium Development Goals (MDGs) combat HIV/AIDS, malaria and other diseases, Kristofferson, (2003). The region hardest hit by the HIV/AIDS pandemic is Sub-Sahara Africa, where 22.5 million people are estimated to be HIV positive (UNAIDS 2010). Sub-Saharan Africa is blighted by HIV/AIDS, however, the UNAIDS report of 2010 does also indicate some positive developments in tackling this challenge. In this report it is indicated that there has been a decrease in the number of HIV new infections in some sub-Sahara African countries. The number of deaths across the region is also reported to have decreased. This decrease is linked to a rolling out of Antiretroviral Treatment (ART) across the region and also wider improvements in medical care. Nevertheless ART remains inaccessible to many HIV positive people across the region.

1.2 HIV epidemic in Namibia

Namibia is one of the countries in Southern Africa with a high prevalence of HIV/AIDS. The first HIV case in Namibia was reported in 1986. Namibia's national HIV prevalence was first reported in 1992 at a rate of 4% of the adult population. By 2000 the prevalence of HIV/AIDS IN Namibia had increased to 22% of the total population. In 2004 this figure was 19.8% of the total population and has stabilized around this level since. In 2006 a slight increase to 19.9% of Namibia's total population was reported (MOHSS, 2008). In 2008 the ministry of health social services reported a clear decline to 17.8 % of the total population. The latest data of 2010 shows a slight increase again to 18.8% of the population (MOHSS, 2010). According to the WHO (2002), AIDS related illness accounted for over 50% of deaths in the adult population in Namibia. This figure dropped to 23% in 2007. This decrease can be attributed to improvements in the availability of Antiretroviral drugs (ARV). While there has been a decrease in mortality associated with AIDS related illnesses in Namibia it remains a major cause of death in the country (MOHSS, 2008).

According to the National Planning Commission (2008) the Ohangwena region of Namibia has an estimated 228,384 inhabitants. This is 12.5% of Namibia's total population. The same report

also indicates that the region's mortality rate had increased by 12% since over decade and that a quarter of households in the region have experienced a death in the family related to AIDS during this period. The Ohangwena region has a HIV prevalence of 20.1% which is higher than the national average of 18.8%. HIV prevalence is indicated to be higher amongst women (MOHSS, 2008). The high mortality rate in the region has created many orphans, most of whom are under the age of 15. The Ohangwena region has the highest proportion of households affected by HIV/AIDS in Namibia. Torre et al (2008) highlighted that poverty, a lack of mobility and gender inequality are all driving factors behind the high prevalence of HIV/AIDS in the Ohangwena region.

1.3 Problem statement

Namibia as any other country in the southern Africa continues to bear the burden of the HIV/AIDS epidemic. This has consequences on achieving developmental priority areas and goals such National Developmental Goals (NDPs), Millennium Development Goals and Vision 2030 of Namibia, which aims at reducing poverty and increasing well being of Namibian people. HIV/AIDS has affected all citizens at all level in the Namibia society (MOHSS: 2008).

Morbidity and illness as a result of the HIV/AIDS epidemic have affected the livelihoods of most rural households in Namibia albeit in different ways. This impact has resulted in labour shortages, a reduction in income, depletion of assets, diminishing resilience of farming and livelihood systems and contributed to vulnerability that may increase food insecurity. Households in rural areas are affected by the direct or indirect impacts of HIV/AIDS through household members' illnesses or death, or the support of orphans.

There have been many studies undertaken examining HIV/AIDS in Namibia, and numerous studies of the epidemic in the Ohangwena region. However there is much less research specifically addressing the livelihoods of HIV/AIDS affected households. There is even less understanding and documentation on the main livelihood strategies of female and male headed households in rural areas and how these livelihoods are changed and affected by HIV/AIDS. It is for this reason that this study examines changes/shifts in the livelihood strategies and activities of male and female headed HIV/AIDS affected households in the Odibo village in Namibia and considers the local support provided to such households.

1.4 Background of the study area

This research study focuses on the Ohangwena region and in particular the Oshikango Constituency. The majority of people in this Region and Constituency live in rural areas and engaged in mixed subsistence cropping and livestock keeping as their main livelihoods. The region is reported to be one of the poorest in Namibia with most households living below the poverty line (NPC, 2001). In the Oshikango Constituency poverty and HIV/AIDS are heavily interconnected. The links between poverty and HIV/AIDS more widely are highlighted by (Niehof, 2010). White and Robinson (2000) similarly highlight how HIV/AIDS contributes to the existing poverty problems of households. Gender disparity in access to assets between men and women contributes to how they are impacted and affected by HIV and AIDS.

This research study aims to provide systematic empirical data about the livelihoods of households affected by HIV/AIDS in Oshikango Constituency of the Ohangwena region. The

research focuses on Odibo village in the Oshikango Constituency. This Constituency is reported most densely populated and also exhibits the highest proportion of orphans in the region and the region's highest household dependency ratio[1] (NPC, 2001).

1.5 Research objective

The following are the research objectives for the study:

- To identify the main livelihood strategies of households affected by HIV and AIDS
- To analyze changes in the livelihoods of male and female headed households affected by HIV and AIDS
- Examine local service providers and the support they give to affected households

1.6 Main research questions

a) What are the main livelihood strategies of households affected by HIV and AIDS?
b) What are the major changes which occur to in the livelihoods of female and male headed households affected by HIV and AIDS?

1.6.1 Sub-questions

- What are the livelihood activities of male and female households affected by AIDS?
- Has there been a shift in livelihood strategies of households affected by HIV/AIDS?
- What are the determining factors in the differences in livelihood activities between female and male-headed households?

1.7 Limitations of the study

Time constraints were a significant challenge encountered during the fieldwork for this research particularly given its longitudinal focus. Nevertheless it is felt that it was possible to collect sufficient data for at least a preliminary examination of the complex issues addressed in this research with scope for future inquiry. Data collection in this study was limited to HIV/AIDS affected households in the Odibo village. This raises questions about the generalisability of the data and the extent to which it can be applied to other communities in Namibia and beyond. It is felt however that there is some scope for the study to provide insights relevant to other villages and communities across the Oshikango constituency and further afield

1.8 Rationale

The HIV/AIDS prevalence in Namibia is 18.8%. The epidemic is mainly reported high amongst active adults between the ages of 15-49 (MOHSS, 2008). Mortality and morbidity related to HIV/AIDS in adults has reduced labour and income in households, and has contributed to the vulnerability of poor rural households. Illness and death from AIDS has also resulted in increasing numbers of orphans, changing household compositions and resulting in Namibia's high dependency ratio. The Multidisciplinary Research Centre within the University of Namibia has carried out applied research in this area. Addressing the HIV/AIDS epidemic is an area of priority for national development of Namibia. The findings of this study will contribute to existing knowledge nationally and will help communities and stakeholders at the local levels to better address and mitigate the impact of HIV/AIDS.

[1] dependency ratio mean is an age-population ratio of those typically not in the labor force (the *dependent* part) and those typically in the labor force (the *productive* part

Chapter two

Literature and conceptual framework

This chapter outlines the conceptual framework for this research and discusses key concepts and how they are operationalised in the study. In this chapter a review of relevant literature informing the research is also undertaken.

2.1 Livelihood

Livelihood is a multifaceted concept this includes activities, capabilities and assets that rural households engage in day to day to make a living. These activities include on-farm, off farm and non-farm either at the household or individual level. Conway and Chamber (1992) as cited in Ellis (2000) define livelihood as people's capabilities, assets and the activities through which they make a living. He further emphasizes the assets and the various activities through which households generate an income for a living. Conway and Chamber definition of livelihood does not recognize assets. Other researcher's like Scoone (1998) highlight the capitals (natural, social, human, financial and physical) and how they contribute to assets in the livelihood definition.

Conway and Chamber (1992) discuss the attributes of livelihoods such as the access individuals and households have to different types of capital, to opportunities and to services. Ellis, (2000: p 10) defines livelihood as:

"Livelihood comprises the assets (natural, physical, financial, social and human capital), the activities, and the access to these (mediated by institutions and social relations) that together determine the living gained by the individual or households".

Ellis (2000) agrees that all the capitals are important attributes of livelihood strategies of rural households. He further explains that Conway and Chamber's define access in a livelihood as the "rules and social norms that determine the differential ability of people in rural areas to own, control, otherwise claim or make use of resources such as land and common property". However, Ellis's definition also strongly recognizes the impact of access on social relationships and institutions and how it mediates individual and family capacity to achieve its consumptions. Many livelihood definitions also fail to recognize that livelihood is not static but is an ongoing process of gaining and loosing assets. According to Ellis (2000), these assets can be destroyed because of external context vulnerabilities, by shocks and seasonality associated with the environment. In addition household's access to livelihood resources and opportunities may change due to the influence from institutions and wider societal factors.

That rural households are involved in a variety of activities to make living is recognized by Ellis (2000). Ellis differentiates between on farm, off farm and non-farm livelihood activities. These different types of activities are distinguished in detail below, they are similarly recognized by Saint (1992) and Leones and Feldman (1998).

Farm income- Refers to income generated from the households own farming account. This is generated from an owner occupied farm or from access to land through cash or by sharing with the owner. The farm income is livestock, crops which are consumed or cash from farm output.

Off farm income- Off-farm income refers to income gained from wages or exchange. Household members may work for different farm/harvest natural resources outside their farming area, they receive payment in kind. Sometimes households may sell to gain income.

Non-farm income- This refers to non-agricultural activities such as employment for a salary, self-employment, when household members send remittances, a pension or a government orphan grant.

Farming is the main household income earner for most people in the Ohangwena region, followed by a pension, wages and salaries, cash remittances and non-farming businesses (CBS, 2001). Thus most people rely on cropping to meet household cereal needs, and livestock (especially small stock) to provide meat for relish. Livestock in generally seen as a safety net sold in times of financial need such as when school fees are required, hospital expenses and during festivities and events such as weddings and funerals. Natural resources also play important role in peoples livelihoods. Different types of wild fruits, vegetables and worms harvested for consumption and for sale.

2.2 Sustainable livelihoods framework (SLF)

According to Ellis (2000) a Sustainable Livelihoods Framework (SLF) is a tool used to help understand the livelihoods of rural households. Through the framework it is possible to gain an understanding of the complexities of rural livelihood diversification. Loevinsohn and Gillespie (2003), Stokes (2003) and Harvey (2003) have all similarly proposed that an SLF can be used in the context of HIV and AIDS to understand how AIDS has an impact on various aspects of rural livelihoods. Nombo, (2007) states that livelihood analysis is based on the capital assets which households draw upon to produce livelihood outcomes.
The capitals used to generate livelihood outcomes are outlined by Ellis (2000) as follows:

- Natural capital: This refers to the natural resources base (land, water, natural resources and trees) that yields products which can be utilized by human populations for their survival.
- Physical capital: This refers to the assets brought into existence by economic production processes, for example livestock, cropping and tools.
- Human capital: This refers to the education level and health status of individuals and a population as a whole.
- Financial capital: This refers to the financial resources that are available to households such savings, pension grants and remittances
- Social capital: This refers to social networks (committees, group membership, extended family trusts).

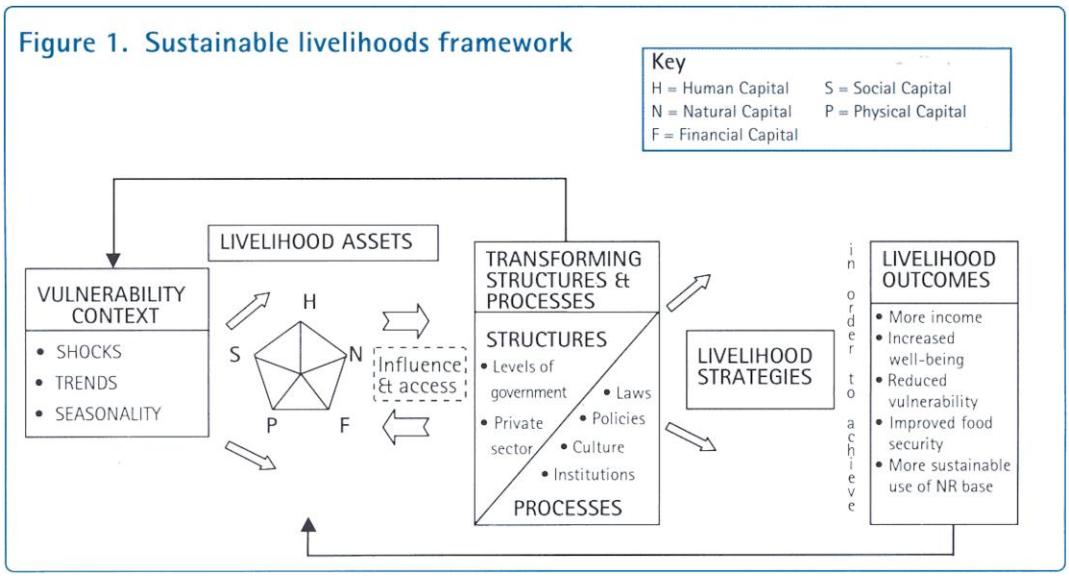


Figure 1 Sustainable livelihood frameworks
Source: DFID- UK (1999)

According to Ellis (2000) and his livelihoods framework it is through these assets (human, social financial, natural and physical capitals) that households make a living. The capabilities and coping strategies engaged in by a household may be short or long term. Ellis (2000) further emphasizes that when the capitals are not in balance this may be due to the vulnerability of the households to shocks, and this imbalance may influence the ability of such households to cope with such shocks. Livelihood assets are sustainable if a household can recover from the external shocks and the seasonal environmental challenges they face. Livelihood strategies consist of the short and long term ways in which households achieve livelihood outcomes, these livelihood strategies may be positive or negative.

2.3 Livelihood strategies

Livelihood strategies are defined by du Preez (2011) as “strategies that are jointly developed by probably the adult household members and that are aimed at strengthening the livelihood system of the household as a whole”. In response to HIV/AIDS households may diversify their livelihood strategies. Some of the livelihood strategies that households divert to may create vulnerability, with this vulnerability often brought on by mortality and morbidity of household member. This vulnerability may likely create susceptibility to further negative outcomes depending on the kind of livelihood strategies households opt for in respond to the impact of AIDS.

According to Ellis (2000), define diversification as “the process by which rural families constructs a diverse portfolio of activities and social support capabilities in order to survive and improve their standards of living”. He indicated that diversification does not associate only with rural households but also applicable to urban households as strategy to make a living. Ellis (2000), classify diversification into two types “a deliberate households strategy and as an involuntary response to crisis”. Types of diversification that households engage into are such as harvesting of natural resources for consumption and sale, crop cultivation, livestock keeping, non-farm, wage and salaries, pension, foster grant and migration in to other areas. Ellis also reported that

the reasons of households to diversify is to “reduce risk, overcoming instability, improving food security, involve in generating cash to meet households needs, gender benefits and decrease vulnerability”.
Some of the livelihood strategies that households divert may also create vulnerability at times as result of mortality and morbidity of household member. This vulnerability may likely create susceptibility depending on the kind of livelihood strategies households may opt for to respond to the impact of AIDS.

2.4 Impact of AIDS on Livelihood

Over the past 30 years since the first case of HIV was reported many studies have been undertaken trying to understand the virus and best way to respond to its effects. Over this period there has been medical advancement in the treatment of HIV which is now better understood. However while medical research on HIV/AIDS has increased according to Niehof, (2010) there remains a gap in knowledge about the societal and structural factors contributing to the spread of the global HIV pandemic.

Nombo (2007) discusses the impact of HIV/AIDS changing the livelihood assets and activities of households. O’Donnell (2004) similarly discusses the impact HIV/ AIDS has on livelihoods but also highlights how this impact varies. This impact may vary according to the assets a households possesses, the demographic composition of a household, or whether this impact is brought about because of chronic illness, a death related to AIDS, or the support of orphans. He further looks at the differences between female and male headed households in terms of assets and composition which he suggests are important contributory factors in impact variation. Both authors share the sentiment that impact varies between households that have been affected by mortality and morbidity related to AIDS and those having to support orphans. This variation in household impact is determined by the assets available in that household. The impact of AIDS is sometimes compound by other shocks in a wider context of vulnerability. Nombo (2007) indicates that the impact of AIDS as result of morbidity and mortality is felt most heavily on households in rural areas, but that there is variation in this impact between male and female headed households. Wiegers, (2004) highlights that when a household member is sick women and girls often have to nurture and care for the sick because of their traditional gender roles. This extra burden and responsibility can impact on the livelihoods and quality of life experienced by women and girls. In Namibia with its high HIV prevalence of 18.8% the impact of AIDS is felt differently by different households. Females and males in Namibia are also affected differently by the HIV/AIDS epidemic.

2.5 Gender in the context of HIV/AIDS

According to Giddens, (1993), as cited in du Preez, (2010), define gender as social roles, constructed by society how they perceived male and female and role and expectations they supposed to perform associated to it them. The gender roles are changeable, but are over time and depend on the culture. Society perceives men as breadwinners and masculine. With the threat of HIV/AIDS, many women and men are also impacted different in the world. According to the SADC (2008) reported that a high HIV prevalence in sub-Sahara Africa is high among women compare to men. The Namibia UNDP report (2001) found that in 1999 women accounted for 54 percent of all new cases of HIV infection in Namibia. Women in Namibia are also diagnosed at a younger age than men, given the median age of HIV diagnosis is 30 years old for women and 35 years old for men. The percentage of young women living with HIV is 29 percent compared to only 8 percent for young men (MOHSS, 2004). In recent years, the impact

of structural factors such as gender inequalities on the severity and spread of HIV has been noted with increasing alarm.
Young girls are particularly at greater risk of HIV infection due to a number of social structural factors. Their earlier exposure to infection is usually by older men who exploit the low socio-economic status of girls and having sexual intercourse with them in exchange for small gifts or money (intergenerational sex). “The impact of HIV/AIDS in Namibia may also be or become gendered in the following ways:

- Younger and more vulnerable women may be at higher risk of infection as men look for younger sexual partners in attempt to find a virgin who is not HIV positive; effects of economic exploitations and cultural myths
- Since women are the primary carers for sick relatives, the burden of caring for relatives with AIDS falls on women.
- For women, there is also the risk of prenatal transmission of the HIV virus to babies, with associated psychological and social burdens
- For both urban and rural women with children and wage earning husbands, the economic consequences during and after the husband's illness and death period are likely to be catastrophic as result of socio-economic and cultural impacts”.

2.6 Conceptual Framework and Operationalisation

2.6.1 Household

Household was the unit of analysis used in this research study. Household is defined as a place was groups or individual live and interacts in various activities to make a living. Other related concepts are the head of household, household composition and family/household structures.
Household is defined by the CBS (2001) as “a group of people related or unrelated, who live in the same dwelling unit and share or have common catering arrangements”. The CBS (2001) further suggests that to determine a household, their composition and the relationship between household members to the head of the household should also be considered. According to Edwards-Jauch, (2010:3) a household is a task oriented residential unit that co-operates economically. She further suggests that households consist of families made up of core members that these members may be related or unrelated as long as they live together in the same dwelling. The CBS (2001) definition of a household also distinguishes between co-residents who live in the household and non-resident who lives away from the household because of work but who contributes to the household through sending remittances or taking on certain responsibilities. The head of a household is the most informed or main decision maker in the household.

According to Nombo, (2007) the head of a household refers to someone who is perceived to be the overall decision maker by members of the household. Households can be male-headed, *de jure* female headed or *de facto* female headed. In this study the majority of female headed households are de jure stemming from the permanent absent of males due to death, separation/divorced, widowing or a legal single. Female de facto households occur when the male head of the household is not present at the time of the study. A household headed by a female with no male present is refered to as “*Okaumbo*[2]”.

[2] Small household headed by a female

For the purpose of this study household is defined as a person or group related or unrelated, who live together in the same homestead[3] but not necessarily in the same dwelling unit. They have common catering arrangements and are answerable to the same head.

2.6.2 Conceptual Framework

The conceptual framework informing this research is outlined diagrammatically see figure 2. This diagram also illustrates the relationship between significant concepts used in this research

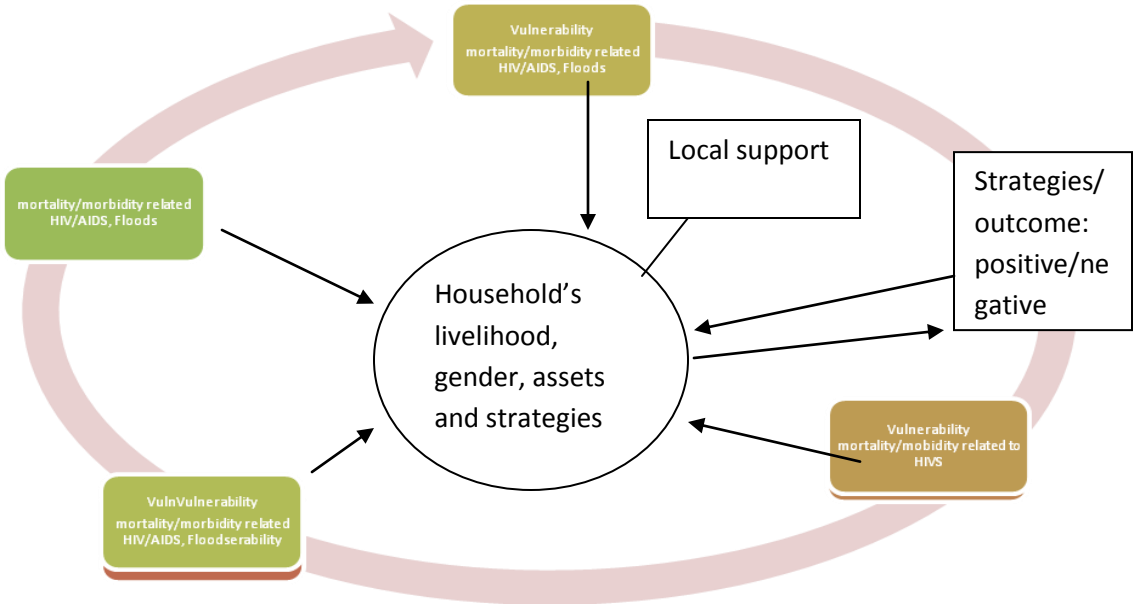


Figure 2: Relationships between the concepts

2.6.3 Operationalisation definition

Household-is a person or group, related or unrelated, who live together in the same homestead, this is both co resident and non-resident, but not necessarily in the same dwelling unit

Livelihood -refers to the way in which a household makes a living, the activities they engage in and the resources they have access to and use.

Household head- a person perceived by the household members as the head of the household, the main decision maker

Household composition- co-residents and non-residents live together in a homestead, related or unrelated but accounting to one head of the household.

[3] traditional house made of wood

Chapter 3

Methodology and research design

This chapter provides a detailed description of the design used to collect data. The chapter concludes with discussion of how the data was analyzed.

3.1 Research design

Multiple research methods were used for collecting data in this study. Firstly, a desktop study was conducted for familiarization with the relevant documentation and materials on HIV/AIDS and households livelihoods in Namibia and the Ohangwena Region.

Different types of questionnaire were designed for the households, for key informants and for the case studies. The study used both quantitative and qualitative approaches and methods. The quantitative method of data collection used comprised a survey of semi structures questionnaires which was used to collect demographic and socio-economic information on the livelihoods of male and female headed households based on the objectives of the study. A total of 20 questionnaires were administered to male and female headed households in the study area.

The qualitative data collection used entailed in-depth interviews with case study households. The case studies were randomly selected from the household's survey. Four cases studies consisting of two female and two male headed households were examined. In interviews with household members in the different case studies at list of questions were devised prior to interviews based on the objectives of the research and built upon preliminary analysis of responses from the survey. Key informant interviews were also undertaken with local stakeholders (a home based care coordinator, volunteers and a health worker at the village level). Information was collected from key informants on the HIV situation in the community and on their experiences working in the village. Interviews with key informants and members of case study households were informal but guided by a list of topic questions. Both case studies and key informant responses were written down and recorded with a digital voice recorder. A digital voice recorder was used to ensure accuracy and that data was not lost or omitted during interviews.
The sample of households for the quantitative survey was selected based on the experiences of home base care volunteers who knew which households were affected through their field visitation in the community. The sampling was done this way because of the sensitivity of the topic and to avoid stigma.

3.2 Data collection

Data was collected during July and August 2011. Households were informed by the home based care volunteers prior to the fieldwork and their consent was gained. Interviews were administered in the local language which the researcher speaks and was later translated into English. On site observation was also carried out by the researcher before and after interviews

3.3 Data analysis

Digital voice recorded interviews were transcribed and field notes typed up and sorted based on the categories and objectives of this research. Content analysis was used to analyze the data which was categorized according to the main themes and objectives of the study. Quantitative data were coded and entered into SPSS to generate frequency tables, charts and cross tabulation for categorical variables. The table and charts data were converted into percentages for summaries.

3.4 Ethical considerations

The research study interviewed households affected by HIV/AIDS, this is a sensitive subject and the researcher sought permission/approval from relevant stakeholders to carry out the study. Permission was granted to carry out the research and fieldwork. The participation of household respondents was voluntary and consent was gained from the respondents verbally prior to the interview. The households were assured verbally that data collected would be confidential. All respondents agreed to take part in the research study.

Chapter 4

Profile of the study area

This chapter describes the socio-economic environment of Namibia as country, the Ohangwena region, Oshikango Constituency and the study site Odibo village.

4.1 Background of Namibia

Namibia is one of the youngest and most stable democracies in Africa today. It is a very large country of 824, 000 km, spanning 1,440 km at its widest point and 1,320 km at its longest. The majority of the population resides in the rural areas. Namibia faces a severe HIV/AIDS epidemic persistently maternal mortality rates and elevated of unemployment estimates at 37% (NPC: 2001) and 51% (MOL: 2009). The countries antiretroviral therapy (ART) has been reported to be excellent. World Bank classified Namibia as upper-middle income due to increase in its gross national income to U$6,200 per capita. However, despite Namibia's economic status recognized to being well, the disparity among the population on the sharing of resources is high, as majority of most people still live below the poverty line.

Namibia is one the driest countries on the African continent, experiencing frequent droughts. Given the limited rainfall, the limited cash incomes, and the dependence of rural households on subsistence farming, many households in rural areas are vulnerable to food insecurity. Widespread malnutrition has been reported across the country, with the highest affected areas in the rural areas (ADB, 2006).

Namibia is situated on the southern Africa, with population of 2.2 million which 51 percent are women and 49 percent men), which is growing at 2.6 per cent annually, (NPC, 2008). The population is relatively young as close to 40 percent of the population is aged below 15 years (NPC, 2003). However fertility rates vary from region to region with an average of 6.9 in the Ohangwena region. Namibia has literacy rate of 84% among its population (CBS, 2001). Namibia has a good economy, but the income disparity distribution between the poor, the rich is huge, in terms of resources, and majority of the population live below the international poverty line (CBS, 2008). Namibia depends on subsistence farming, fishing, tourism, mineral such as diamond and uranium.

4.2 Profile of Ohangwena region

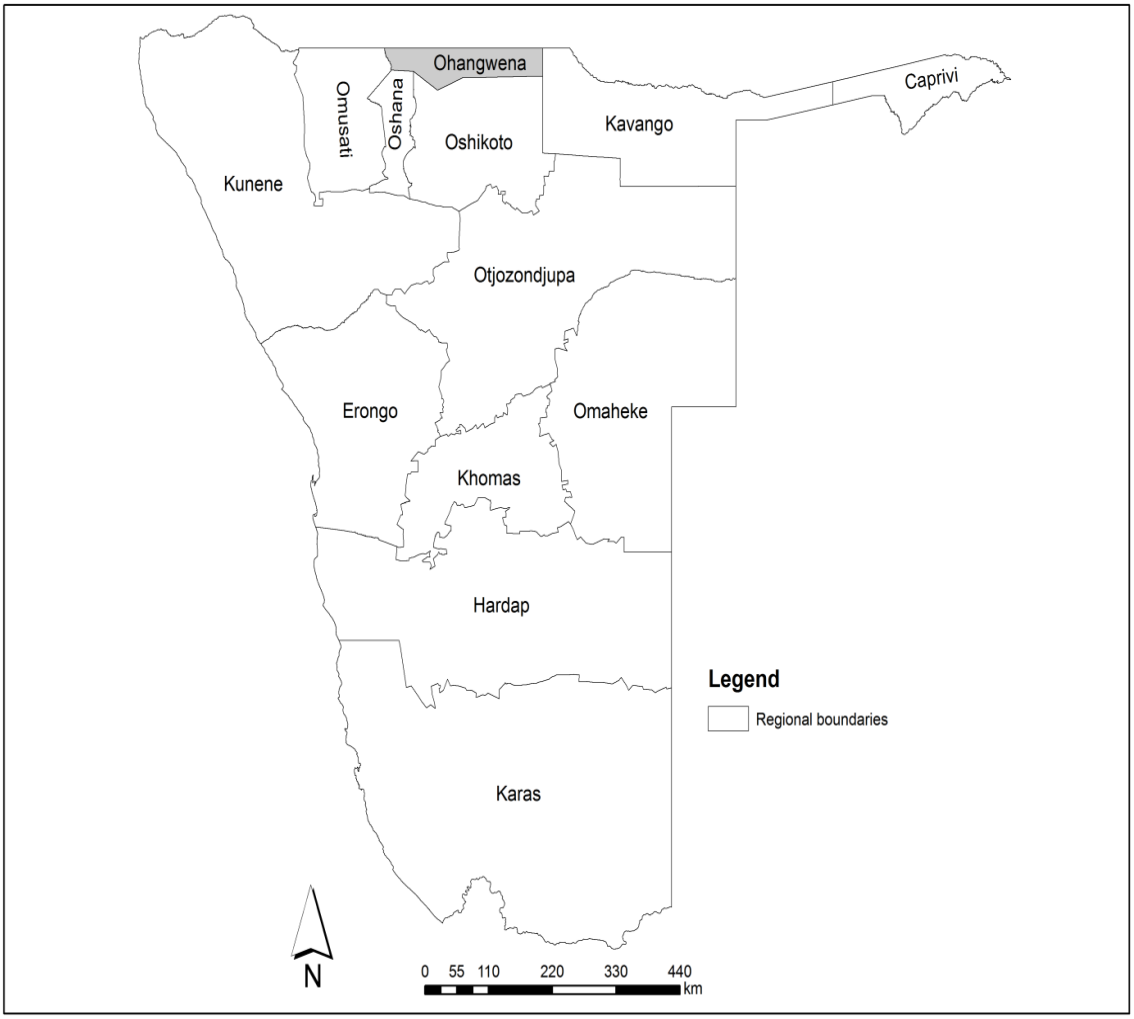
The Ohangwena region is situated in the north central of Namibia and borders the Omusati, Oshana, Oshikoto and Kavango regions. Ohangwena region is the poorest region in Namibia (CBS, 2001). The region has a HIV/AIDS prevalence rate of 20.1% above the national average (MOHHS, 2002). The majority of households in the region are reliant on subsistence farming activity, with crops and livestock rearing the main source of livelihood. The region has a 4% employment rate (CBS: 2001). The region comprises of ten constituencies of which the Oshikango Constituency is one. The Constituency has a high number of mobile people trading between Namibia and Angola because it is situated at the border.

The main language spoken in the region is Oshiwambo languages (97%). The main livelihood activities in the region is farming of crop production, livestock keeping), pension, wages and salaries, business and non farming. The majority of the residents of Ohangwena region are engaged in ploughing millet[4] (known locally as mahangu), sorghum and beans. Firewood is very essential to most of the household in the region as 94 % of household use it as the source of energy (CBS, 2001).

The main source of income in rural areas is farming 52 % and pension 20% while in urban areas most people (13%) earn income through employment (CBS, 2001). The majority of people are employed at government and non-governmental organizations. Other earns wages through self-income generating activities, cash remittances and business. Most of the households (78 %) in the region have access to safe water (CBS, 2001). People in rural areas depend on public pipes and boreholes for their water while a small percentage of the household get their water from the dams and wells. Land is mainly used for agriculture which is the core livelihood activities of most people in the region especially the unemployed. It provides most of the food consumed in the household in form of carbohydrates from mahangu meal, protein from livestock (meat and milk), and crops such as beans and groundnuts.

The literacy rate of those 15 years and above is 79%, with never attended school (23%), currently attending (23%) and left school (51%). The number of children between the ages of 6-15 years attending school is 53% of girls and 47 boys.
Housing structures in the region comprises of detached[5] houses, semi-detached[6], apartments, guest flats, mobile homes such as tents and caravan, single quarters, traditional dwelling and shacks. The traditional dwelling dominates (CBS, 2001), **see map 1**.

[5] A detached house is a house on its own or without an outhouse and not attached to another house (Central Bureau of Statistics, 2001)
[6] A semi detached is a house which is attached to another but with its own facilities and a separate entrance (Central Bureau of Statistics, 2001)



Map 1: Map of Namibia showing the different regions in Namibia and the location of Ohangwena region

4.3 Oshikango constituency- Odibo village

4.3.1 Social context

This constituency is situated on the northern part of Ohangwena region between the border of Namibia and Angola, **see map 2**. The Oshikango constituency has population of 27 599 inhabitants, characterized by urban and semi-urban north-west part of the constituency and deep rural in the north and east. The main urban centre called Oshikango consists of large business complex, warehouses, and wholesale, consist of four commercial banks, hotels, police station and a fuel stations. There are several secondary and many primary schools.

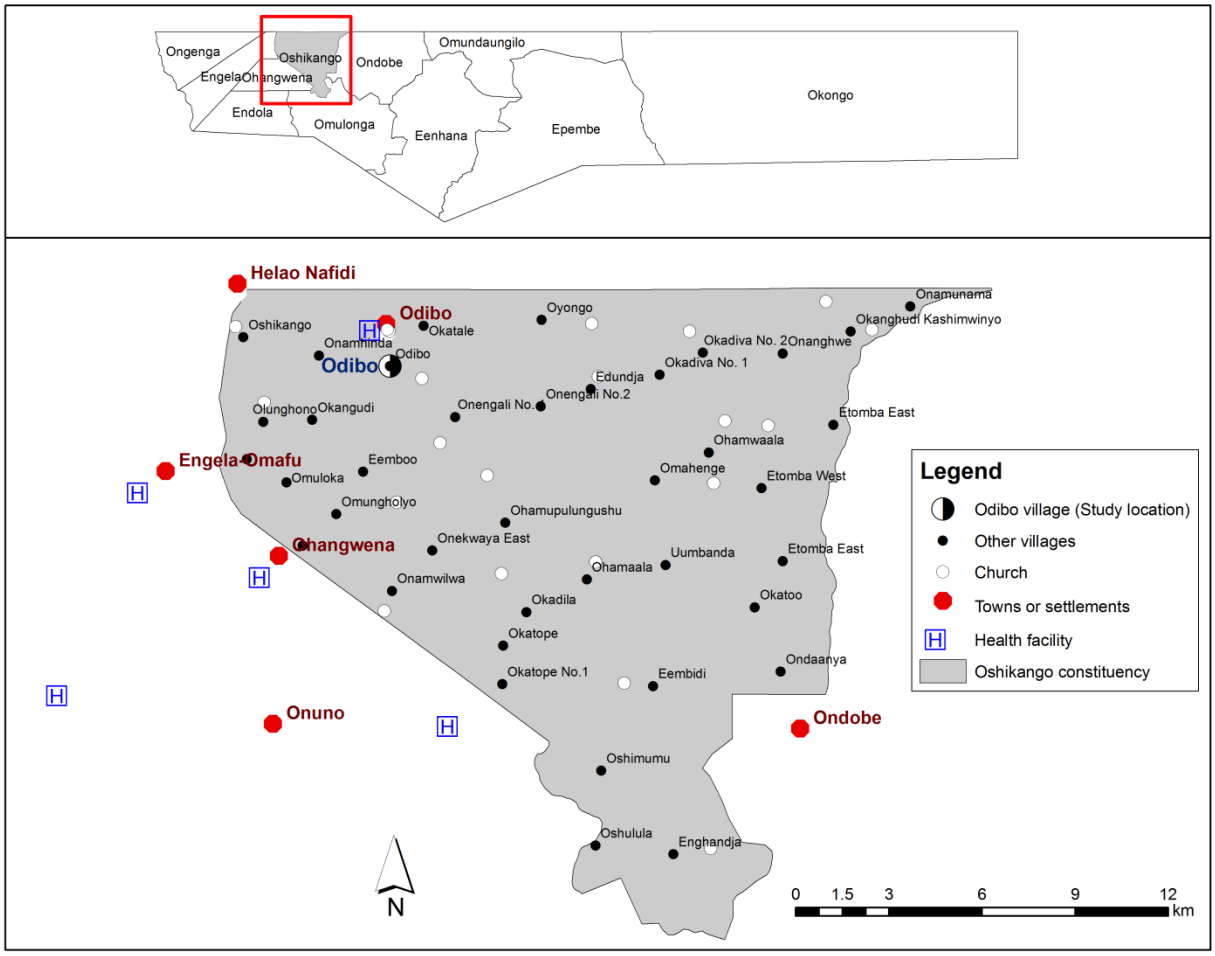
The Constituency has a high number of mobile people trading between Namibia and Angola because it is situated at the border. Odibo village which is the focus of this study is situated in the Oshikango Constituency. The study site is situated five kilometers from the Constituency's main centre. It has a high school and junior primary school, a health centre which is the biggest in the constituency.

4.3.2 Economic context

Farming (cropping and livestock) is the main livelihood of household followed by pension, wages and salaries, cash remittance and non-farming business (CBS, 2001). Thus most people rely on cropping to meet household food needs and livestock (especially small stock) to provide meat for relish. Livestock in general is seen as safety nets to be sold in times of dire financial need such as school fees, hospital expenses and during festivities and events such as weddings and funerals. Natural resources also plays important role in people's livelihoods. Different types of wild fruits, vegetables and worms are harvested for consumption and also for sale. There is a gravel road connected between Odibo village and Oshikango main centre. The Oshikango main centre is constituency is connected to urban and semi-urban within the region via tarred roads, while gravel roads and sandy roads connected to villages within the constituency. According to the Census (2001) 86 percent of the people have access to clean water, including the Odibo village.

Schools and Health centre

Oshikango Constituency has a high school situated at Odibo and many pre-primary, primary and combined schools in different villages of the Constituency. The Constituency consists of one main health centre, which is situated at Odibo village, with several clinics. The health centre at Odibo village provides services such as prevention from mother to child transmission (PMCT), voluntary counseling and testing (VCT), family planning, screening, treatment of patients, Health education and it has communicable disease clinic that provides ART and ARV to those HIV infected. the health centre consist of inward and outward patients.



Map 2: Map of Oshikango Constituency showing the location of the study Area Odibo village

Chapter 5

Results of the study

5. 1 Demographic characteristic of households

During data collection a total of 20 questionnaires were administered for the survey to both male and female-headed households affected by HIV/AIDS. Of the twenty respondents 11 were female and 9 male headed households. There were slightly more female than male-headed households interviewed. About 55 percent of household heads were females most of who were *de jure*, with 45 percent males, see figure 3**.** This data correlates with the National Census results which show that 60 percent of the households in Ohangwena region are female-headed households and 40 percent are male-headed households (CBS, 2001).

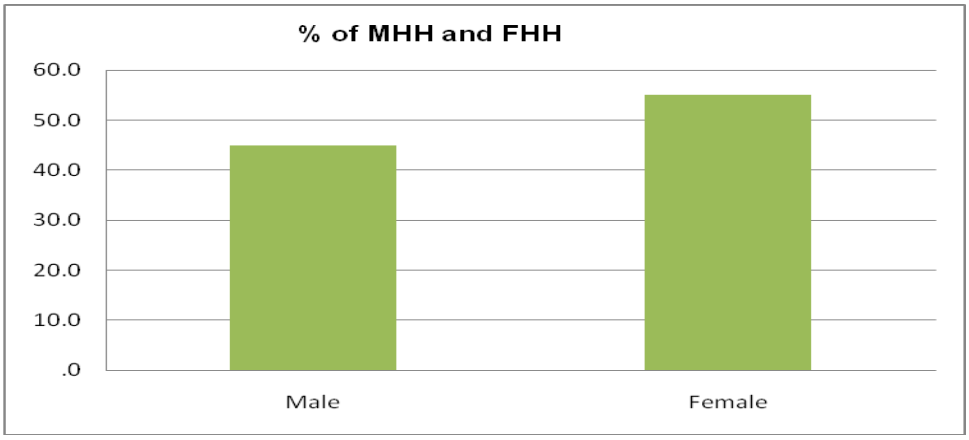


Figure 3: The number of male and female respondents

The chart below provides a breakdown of the ages of the respondents in this study. The majority are elderly (60 %) above the age of 60 years with equal numbers of both male and female respondents. About 40 % of the respondents were in the age group of 30-59. This indicating the youngest head of household was 30 years with the oldest 99 years; the average age for a head of household was 61 years

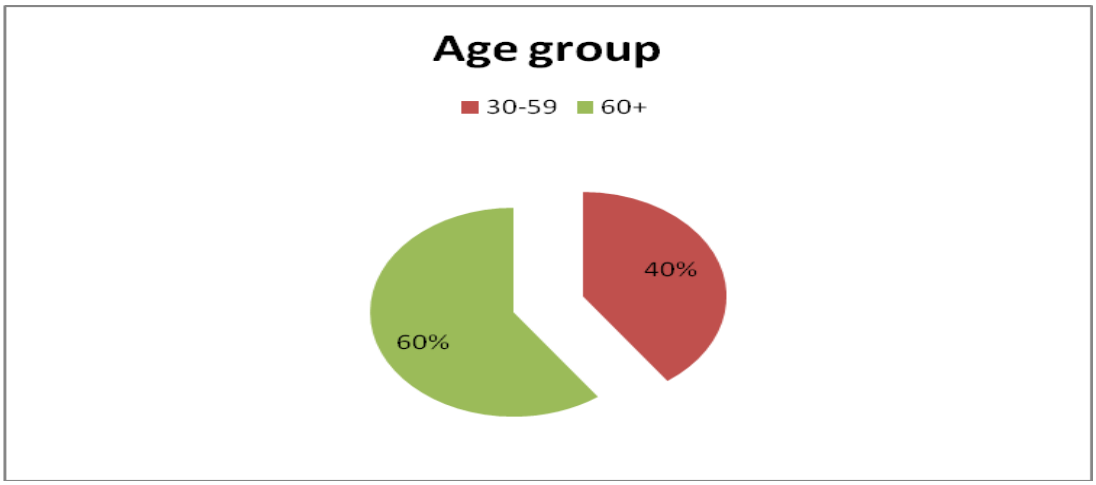


Figure 4: The age structure of the respondents.

5.2 Household size and composition

Of the respondents (85%) indicated that their family structure included extended family with only 15% describing themselves as a more nuclear family. The household size ranged from 2-33 persons, this includes both co and non-resident members. 50% of the households questioned indicated that there had been an increased in the number of household members in recent times primarily due to the birth of new children in the households. 35% of households that the number of members was unchanged, while 15% of households indicated that there had been a decrease in members due to death, migration or members building their own households.

5.3 Loss and illness of supportive family members

65% of the male and female-headed households questioned had not lost supportive family members from HIV/AIDS related illnesses over the past two years. The remaining 35% of households interviewed indicated that they had lost such a member over the last two years due to illness related to HIV/AIDS. Those households that had lost a supportive family member stated that due to that loss their financial situation had deteriorated, and that their ability to cultivate crops and their ability to purchase food had been reduced.

90% of male and female headed households indicated that they had family members who were sick from illnesses related to HIV/AIDS. The average number of HIV infected persons per households was 2. The heads of household indicated that the illness of household members affected the livelihood of the households because they spent more money on food. Several were dependent on extended family or neighbours for financial and food support

Some respondents indicated that household income had been reduced because some ill members had stopped engaging in income generating activities as result of them weakening due to illness. Others stated that there was a decrease in food production in households as members could not cultivate the same size of field. Households also mentioned that the impacts of illness related to HIV/AIDS were compounded by floods damaging crop fields and increasing low soil fertility which had been a problem for five consecutive years. These factors had all contributed to low food production.

5.4 Type of dwelling of households

More than 7 of the male headed households in the Odibo village were reported to reside in traditional huts dwellings. This is proportionally higher than female headed households 2 of whom resided in brick dwellings, see figure 5.3. Hut homesteads are the most common dwelling type in the study area followed by homesteads with both a hut and brick dwelling.

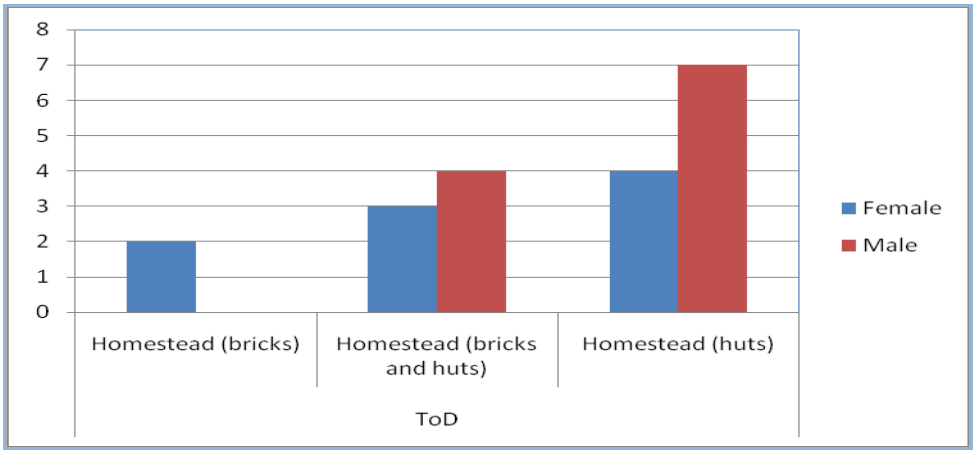


Figure 5: Households by type of dwelling

5.5 Main livelihood activities

The households in Odibo village were engaging in various kinds of livelihood activities. Through the findings it is clear that cropping (mainly mahangu (millet), sorghum and beans), pension funds and natural resources harvesting are the three most important livelihood activities for the interviewed households, see figure 5.

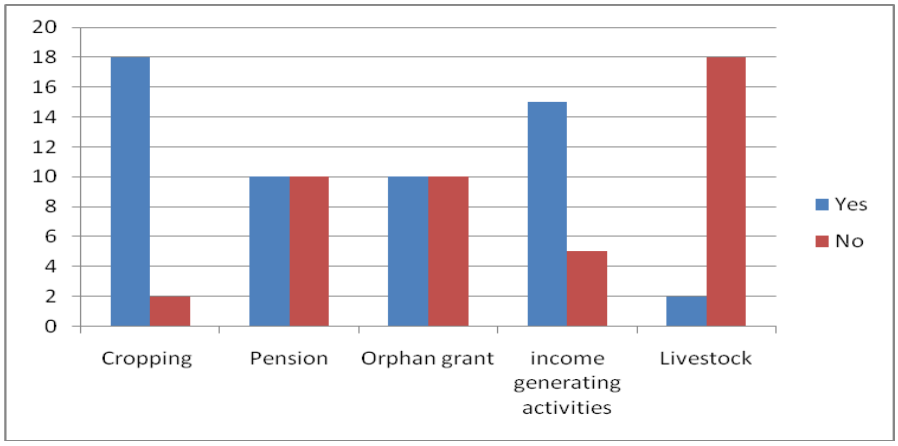


Figure 6: **Livelihood activities and their importance**

Cropping

Cropping constituted the most important livelihood activity for the households questioned. Its importance was stated by 18 of the 20 households. The majority of the respondents grew mahangu followed by sorghum and beans. Other common crops included maize, watermelons

and pumpkins. All households interviewed ploughed their field with *etemo*[7]*, with a* few ploughing with an animal using *oshipululo*[8] and a tractor. Animal draughts were only owned by a few male-headed households, other households hired tractors and draught animals from their neighbours to use. All of the households interviewed mentioned that they had cultivated their fields in the last rainy season. However most of their crops had been destroyed by the heavy floods which the households have experience for the past five years.

Households further mentioned that they were also engaging in a wide range of livelihood activities to reduce vulnerability in times of difficulty e.g. if crops fail they will rely on pension, income generating activities, orphans grant or on livestock.

Other sources of income

Sources of income for the households included pensions, orphan grants, disability grants and the selling of indigenous products and livestock. Old age pensions and the orphan grants were the most widely accessed source of income by the households interviewed, with a few earning extra income from selling indigenous products. One household was reliant on the disability grant of an adult in the household. About 80% of both male and female-headed households relied heavily on pension and orphan grants and the selling of indigenous products.

Indigenous product resources

All the households that were interviewed harvested natural resources. Natural resources were used for many different purposes such as consumption, sale, handicraft, and as building materials. Wood is very important as a source of energy and for building materials. Wild fruits and vegetables were collected for both consumption and sale especially when households needed cash. Traditional drinks such as *Ombike*[9] and *marula*[10] *juice* were produced from wild fruits.

5.6 Changes in livelihood due to illness or death

Household were asked if they had experienced a change in their livelihoods due to illness or death. 65% of both male and female-headed household agreed, that they had to change their livelihoods as result of illness and death, while seven female-headed households indicated that there had been no change in their livelihoods. Those who indicated that there had been a change highlighted constraints on their livelihood state and that they had experienced a reduction in income due to members being sick and not able to partake in the income generating activities, see figure 7.

[7] hand hoe plough,
[8] hand held plough
[9] traditional gin made from wild fruits
[10] traditional juice brew from marula wild fruits

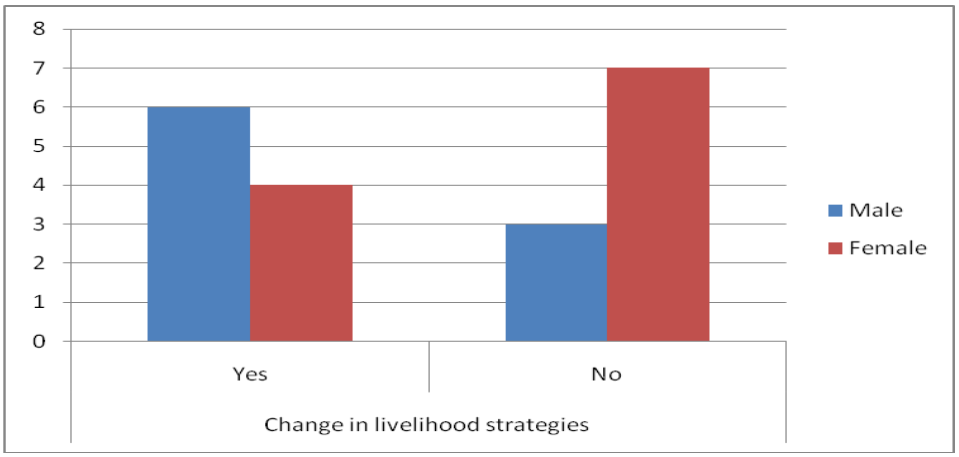


Figure 7: Changes in livelihood strategies of MHH and FHH

As household lost active younger members this lost was felt in a loss of labour and a decline in harvests. Of those households interviewed 35% indicated that there had been no change in livelihoods because of illness or death, however they highlighted the effects of floods. It was also suggested that while those that are ill in their households do not contribute financially they were nevertheless able to get involved in household activities like cultivation, which it was suggested were less affected by illness.

The findings from interviews with key informants shared many of the sentiments of the affected households. Key informants indicated that most households had accepted HIV/AIDS but that poverty is a key challenge faced by all of the households. It was stated that because the main livelihood activity of many households is crop cultivation and for the past five years such activities have been badly affected by floods and high rain fall that have destroyed crops, households could not harvest enough food and this has contributed to increased food insecurity. "*The changes in affected households are that families have accepted HIV/AIDS, there is less stigma and discrimination in households; females are more open to accept HIV compared to males" (**Omwenetumenge home base care- Coordinator).***This finding reflects the situation in one of the households as outlined below.

Box 1

*'My name is **Frieda Nandjebo, 60 years** of age, both my husband and me are AIDS patient, I got sick last year and I have been in bed for the past two months while my husband is blinded by the illness. I am on ARV. God blessed me with three daughters and four sons, one of my daughters and my grandchild are HIV infected. After I was discharged from hospital I now live with my sister Emilia who is a teacher. My livelihood has change because although God blessed me with the strength to cultivate my fields due to illness I now cannot cultivate it and the little I was able to cultivate were destroyed by the floods. Now that I take ARV, I can do a little work. Now we depend on the pension that I started receiving last year, but my children also support us financially."*

'*Nelao Handjaba, 33 years, HIV positive, I have three children, they all get a government grant. I have house in Ondjajaxuima but I have lived in Odibo for the past five years. I left my village to settle here because of a lack of food and illness. I live in poverty because I have no other source of livelihood apart from the orphan grant and selling of marula or veldt fruits to get money for transport to collect ARV medication or buy food. I travel to Engela hospital to collect medication when I have traditional gin, marula fruits and baskets. My livelihood has not changed, even though I would not do the same work as before. I still live the same way apart from having less strength due to illness but with ARV medication I am able to carry out work even though not as much as before the illness".*

Although all households indicated that the cultivation of crops was their main livelihood activity, illness and floods had resulted in less food production from the fields. Households both young and elderly highlighted that pension and orphan foster grants were an important source of income in the households. The crops they were able to harvest from the fields after flooding were not sufficient, households were increasingly dependent on pensions and orphan foster grants for their livelihood. These findings are explained by one of the respondents, as illustrated in box 2 below.

Box 2

*Cultivating crops has always been our livelihood. However for the past five years I have not yielded enough crops from my field because of the floods that have destroyed my field. My household has been depending on the pension to buy maize meal, relish, and to pay for school fees and other basic needs. Therefore, I thank the government for providing elderly households with a pension, how would we have been surviving without it. We have not been receiving the food aid that we use to get whenever we did not get much from our field." **Female headed household 87 years old**.*

5.7 Household's monthly budget on various expenses

All of the male and female-headed households interviewed were asked to estimate the amount of their monthly expenses. The figures 8 below show that male headed households spend more money ($600) on food monthly than female headed households. The results indicated that male headed households have double income of the male head and spouse.

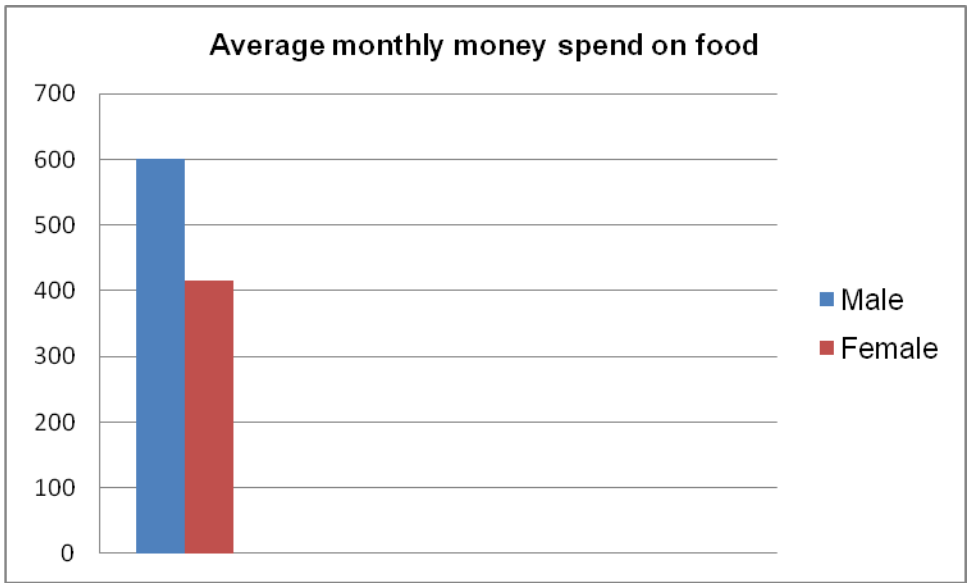


Figure 8: Monthly money spends on food by male and female HH

The average amount spend on hospital fees by households, the result indicates that female headed households have spent more money on hospital fees compare to the male headed households, who on average only spend N$80 in the past twelve months not monthly as the previous graph, see figure 9.

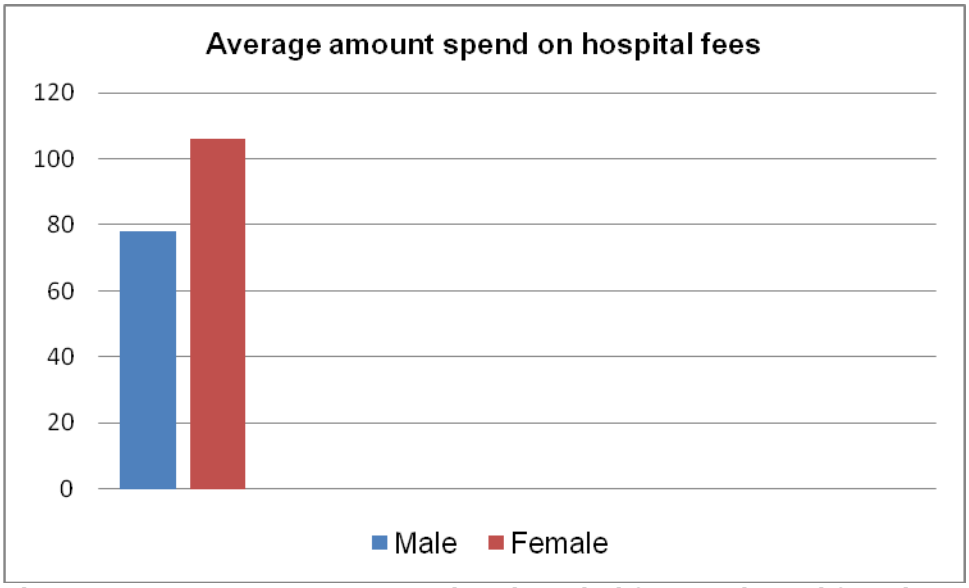


Figure 9: Average amount spend on hospital fees male and female HH

This figure below indicates that male headed households spending on average more money on school fees of N$1100, with female headed households spending only N$194 on average. Some male headed indicated to pay more on the school fees because their children attend tertiary education which is more expensive.

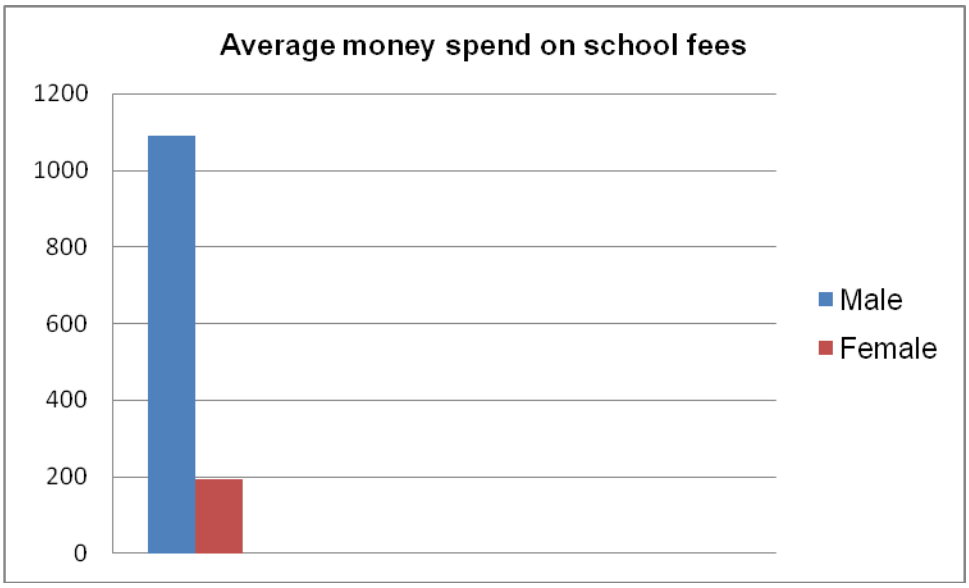


Figure 10: Average amount spends on school fees by male and female HH

Households hardly spend their income on clothes as results reveals male headed spend on average of 200N$ on clothes, with female headed households spending even less than male headed households. Most households indicated that clothes were not as important compare to other expenses, see figure 11.

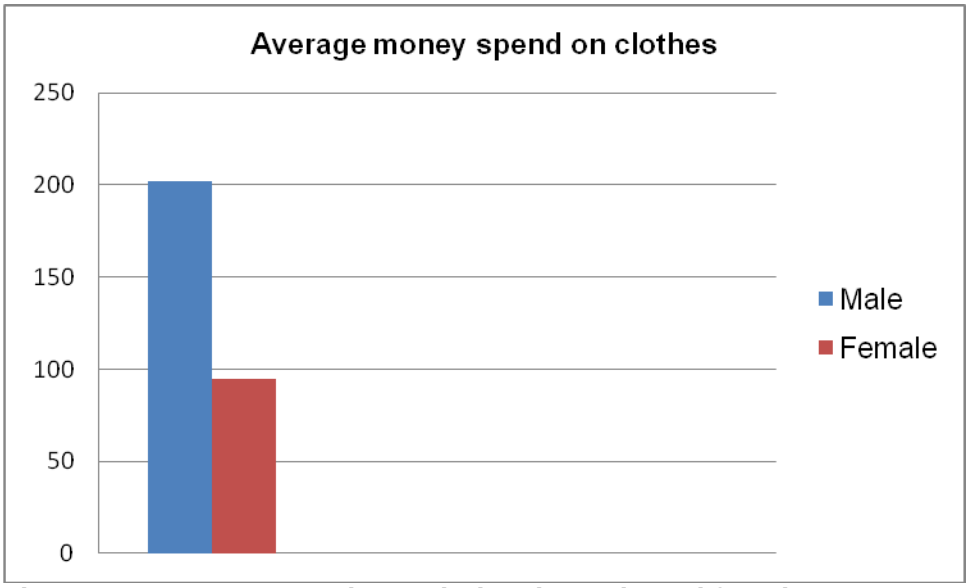


Figure 11: Amount spends on clothes by male and female per HH

Most households indicated to spend less on transport, as most interviewed households indicated to be in distance to the health centres. Male headed households indicated to spend on average N$110 compare to female headed households who only spend N$100. Male and female household's spend less on transport compare to other expenses, see figure 12.

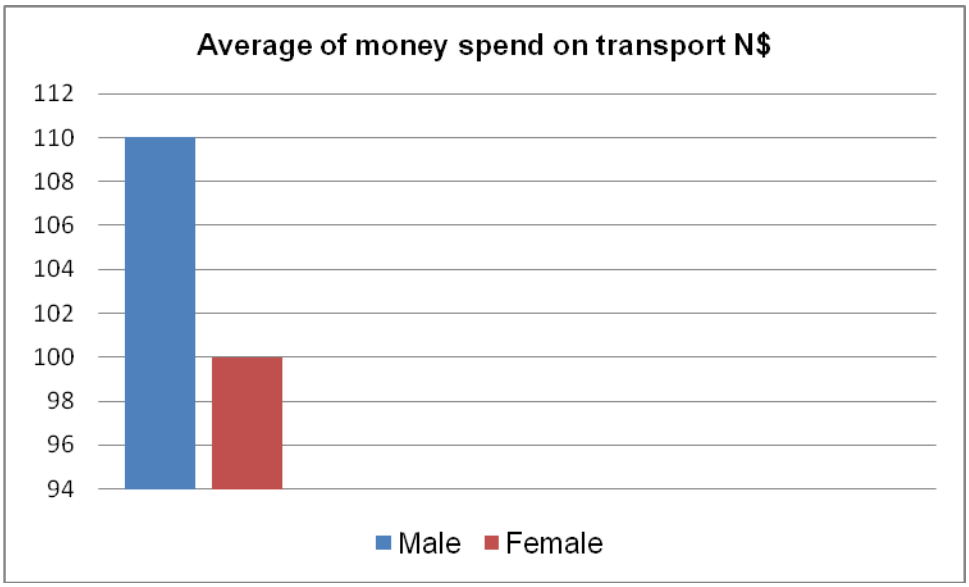


Figure 12: Amount spend on transport by male and female HH

All figures above shows the amounts of money spend on various expenses by male and female-headed households. The male-headed household's indicated that on average they spent more on food, with highest spending of 600N$ per month; the highest female spending was N$416 on average. The results show that most households spend more money on food than any other expenses; with an average income of most households estimated is N$ 800.

The male-headed households are shown to spend more than female headed households. The respondents were asked if the source of their incomes had changed as a result of illness or death. About 50% of male and female reported that their income sources have changed. Household mentioned that illness has reduced their income as adult ill household members do not participate in the income generating activities they were involved in. Households indicated that they spent more on food as a result of crops destroyed by the floods. 50% of households had seen no change in their sources of income because those that were ill had not contributed to the income of the household.

In the households it was stated that the expense most affected by illness and death was food, with about 35% of households, indicating food. 10% of households indicated that payment of school fees had been affected while 5% mentioned clothes and blankets respectively. The other 45% of household heads indicated that none of the expenses in the household were affected because those who are HIV infected now receive free treatment at the hospitals; they are not required to pay.

Although household heads indicated that food was affected by illness, 80% also indicated that food was the biggest expense of their households, followed by school fees and least of all transport. About 50% of households indicated that if they cannot pay for these expenses, they borrow from their neighbours to pay back after receiving pension or orphan foster grant. 25% stated that they do not have other alternatives such as borrowing from neighbours or engaging in income generating activities to pay expenses.

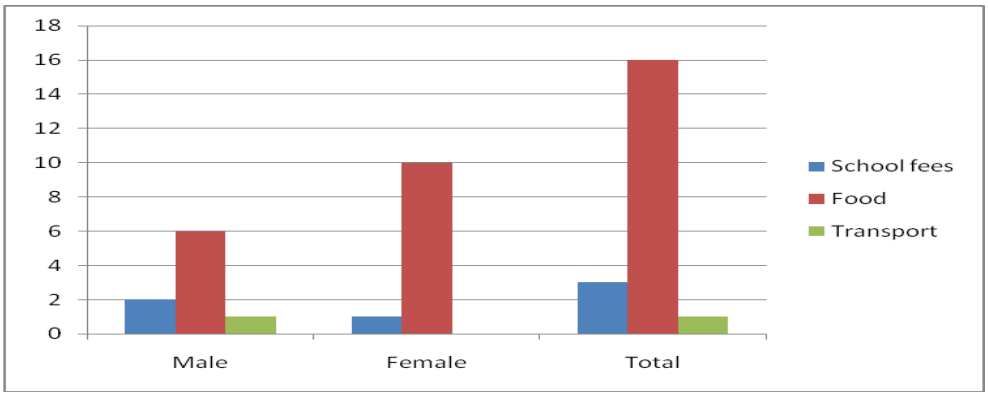


Figure 13: The biggest expenses for MHH and FHH

5.8 Households Assets

All the households interviewed own land to cultivate and live on, 10% of the households owned livestock. About 80% of the households interviewed mentioned that they do not own assets such as cell phones, bicycles and shop that they can sell. 20% of the household interviewed did own such assets, only one household owned a shop which was sold after the death of the husband, and another three households sold chickens when they needed cash.

5.9 Social capitals

From the findings it is evident that social capital plays major roles in the study areas. About 50% of the respondents questioned received food support from either neighbours or extended

family. It was stated by 45 % that they did not receive any support, while 5% received clothes, assistance of cultivating their field and financial support respectively.

60% of the male and female-headed households indicated that they would turn to their neighbours for support during times of difficulty, female headed shown to be the majority. 25% indicated that they would approach their extended families. 10% of respondents stated that they would approach home based care volunteers, while 5% said they would approach biological children. Although it was not included in the questionnaires, all of the households interviewed suggested that that they received a lot of support from home based care volunteers in the form of counseling, emotional support and making sure that those on ARV went each month to collect their medication. Some of the heads of household indicated that home base care volunteers would sometimes collect the medication of ill family members on their behalf. In some instances an arrangement had been reached between HIV infected persons, their families and the volunteers. Of the households interviewed 90% of them indicated that for the past twelve years they had never received food aid, 10% stated that they had received food aid. This food aid was provided by the constituency councilor and was given once a year.

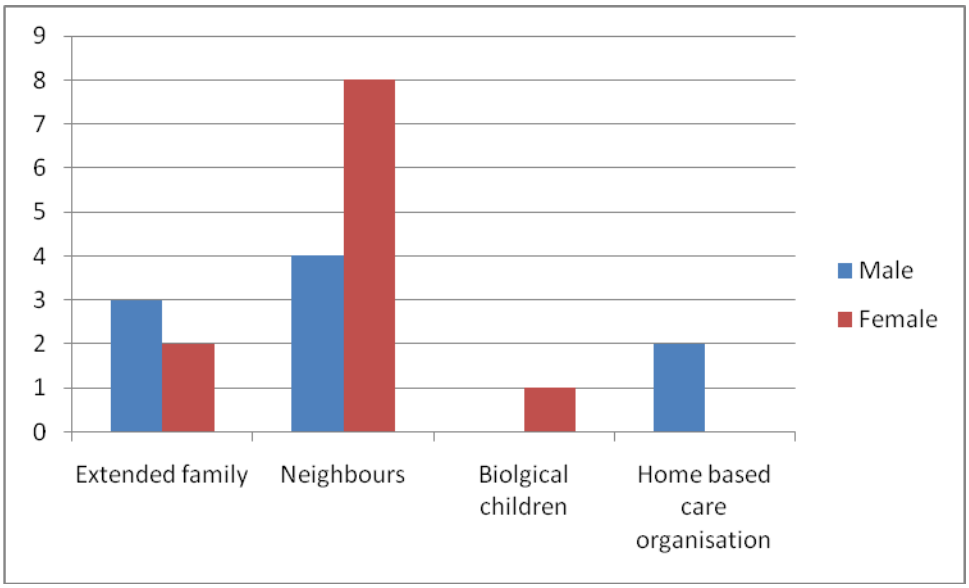


Figure 14: Social supports for male and female HH

Home based care

This study reveals that importance of home based care volunteers visitation to affected households. The volunteers provide paracetamol to patients if they are in pain, sugar for oral rehydration, and plates to wash the hands, faces and clothing of patients during visits to the households. Volunteers also provide health education to households members. Previously the home based care programme also used to provide crops (mahangu, beans), fish, caterpillar, and bread to AIDS affected and destitute households in the study area.

Caring of orphans

The household studied in this research not only care for sick adults, many were also caring for orphans whose parents have passed away. Of the households surveyed 85% had a child without a parent (s); (They had lost one or both parents). Of the female headed households questioned 45% cared for orphans, this figure was 40% for male-headed households. The

heads of these households indicated that to care for these orphans they used their pensions in the case of elderly lead households, orphan grants of N$270 per orphan child and N$100 for each orphan child in the households, extra income-generating activities, and some non elderly headed households received rations from local schools for orphans.. Most of the orphans in the households had lost at least one parent to an illness associated with HIV/AIDS in some instances it was stated that it was not known what illness had killed the parents of orphans. There were a number of orphans in some of the households who were not receiving an orphan grant; this was because they were still in the process of being registered, largely due to their fathers not being known by the family and outstanding documentation. This situation was similarly described in interviews with key informants. Key informants indicated that volunteers would also help households in registering orphans for government grants or direct them to places where they could be registered. Some households were found to be unaware of government grants; however the majority was, largely due to information provided by the volunteers. Households face challenges in registering orphans. When the father and/or mother of orphans die their documents may be lost or difficult to trace. It sometimes occurred that an orphan's mother has died but the family are not aware of the father **(Home based care facilitator, Odibo).**

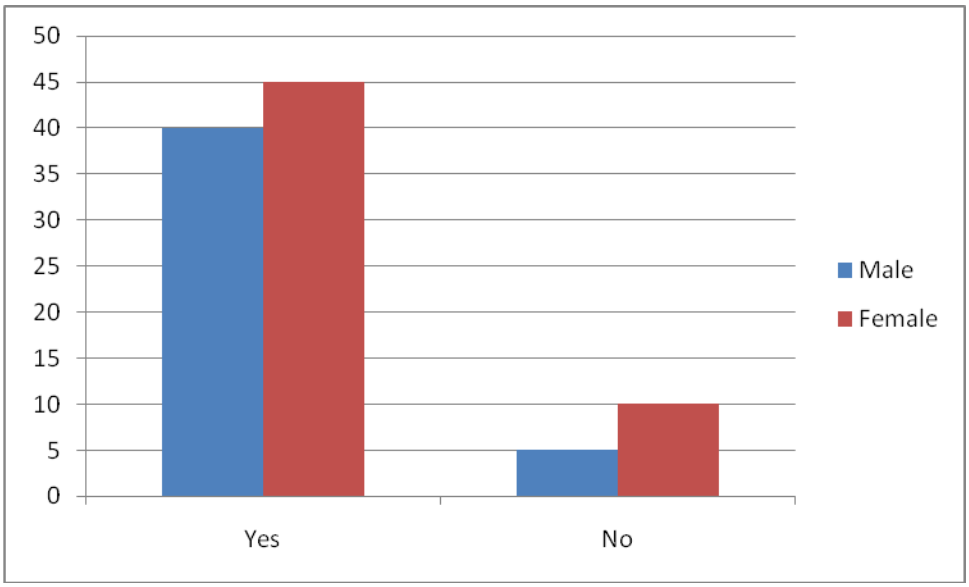


Figure 15: Percentages of MHH and FHH caring for orphans

Most households 45% sustain the orphans with the foster grant; while 15% indicated income generating activities. Others few of the households mentioned pension and food ration of 10% respectively see table 1.

Table 1: Different ways of sustaining orphans in male and female HH

Various ways of sustaining of orphans by male and female HH	Percent
Government grant	45.0
Ration provide by the school	5.0
Income generating activities	15.0
With pension	10.0
With Crops from the field	10.0
No orphans in the HH	15.0

5.10 Migration in livelihood strategies

Of the households interviewed 35% indicated that someone from their household had migrated to urban areas. It was stated by 20% that they had migrated in search for employment while 5% had migrated to carry out food for work, care for another household and schooling respectively. Those households in which members had migrated indicated that it was a seasonal migration, with males more often migrating. 65% of households had not had members migrate.

Key factors contributed to a change in the livelihoods of households and their livelihood strategies are shown in the figure 16 below

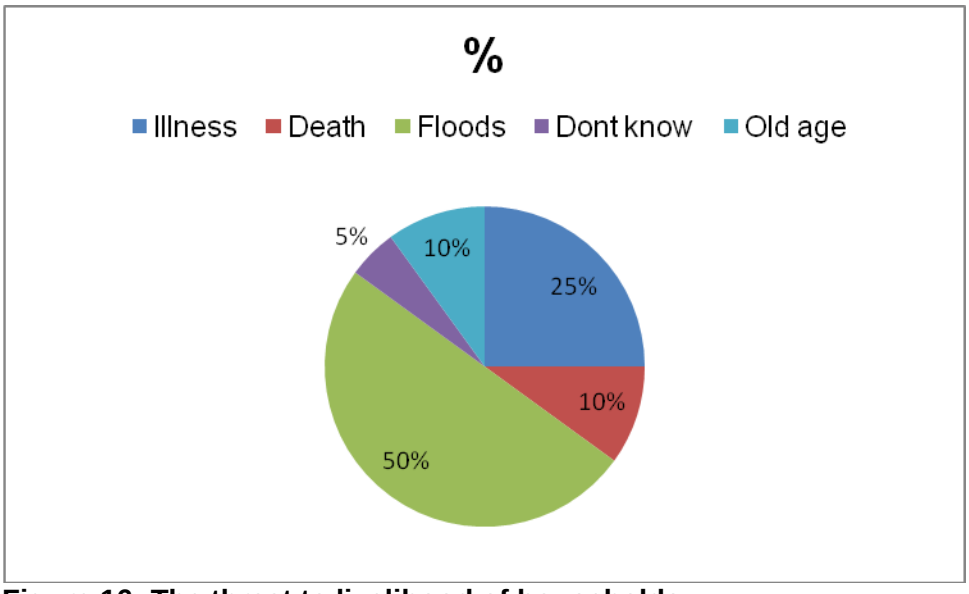


Figure 16: The threat to livelihood of households

Of the households questioned 50% indicated that flooding was the biggest threat they faced to their livelihoods. 25% identified illness related to HIV/AIDS as the biggest threat. Of the remaining respondents 10% identified death and old age respectively, 5% did not know. Of the respondents 75% identified flooding or illness related to HIV/AIDS as the primary threats they

faced to their livelihoods. Households cope with these threats using their pensions, orphan grants, engaging in income generating activities or by support from their neighbours.

Chapter 6

Discussions of the findings

6.1 Household compositions

The negative impact of HIV/AIDS on Namibian society has been substantial. It has affected the livelihoods of people living across Namibia in different ways. In the study area the HIV/AIDS epidemic has changed the social structures of households. The findings of this research reveal more female headed households in the study area. Most of the households studied are headed by the elderly, of which most of them were female headed. According to the 2001 Namibian census the Ohangwena region has a high number of female headed households The findings of this study reveal that many households in Odibo are headed by elderly who traditionally are supposed to be retired from active work and caring for children. These elderly heads of household have however found themselves in a reversal of roles. They are increasingly required to act as caregivers. They are also taking on responsibilities to be the primary provider/breadwinner for active sick adults and orphan children in their care. The study shows a high dependency ratio within households in Odibo, the majority of these heads of household are elderly above the age of 60. In some elderly headed households had active adults within them who were not ill but were still relying on the pension of the head of households. Topouzis, (1998) indicated that "AIDS illness and death result in a rise in the number of dependents relying on a smaller number of household members; this increases dependency ratios in households". This affects the livelihoods of households and leads to increasing adjustments in the roles and responsibilities of household members, for example elderly both male and female are forced to become providers and care givers to both orphans and adults of working age who are sick and unemployed. The HIV and AIDS epidemic in Namibia has changed the landscape of rural life and the social organization of households in the country completely.

Female-headed households in this study generally had higher numbers of household members than male-headed households. Most of the female head of households were either widows or were legally single. Male head of households largely had spouses. All the male and female-headed households over 60 years of age relied on their pensions as their main source of income. The male and female-headed households in the study disclose few differences in assets ownership. However households that were male headed tended to receive a pension for both the male head of house and their spouses meaning that they were often better off in comparison to single female headed pensioners. This double pension almost doubled the income of these households.

6.2 Main livelihood activities

The findings of this study shows that most households are engaging in diverse livelihood activities to make a living. Most the households (90%) revealed crops as their main livelihood activities, followed by pensions for elderly households and orphan foster grants for both young and elderly headed households. It is evident that cropping of millets, sorghum and beans, pension, foster grant and income generating activities were most important to the households. The results of this research show that only a very few households in the study areas owned livestock. Although the Annual Agricultural Survey (ASS), indicated that Ohangwena is one of two regions with the highest number of livestock in North Central Namibia. The study findings

reveal that all the households depend on cropping as source of their livelihood. Farming of crops and livestock rearing are the main household livelihood activities for most people in the Oshikango Constituency (CBS, 2001). Most people rely on cropping to meet household cereal needs. The pension was found to be the most important source of income in the elderly households examined in the research. In other households the orphan grant of N$ 270 per month was important to households. The study shows that some of the households were receiving an elderly pension grant and also an orphan foster grant. Namibia alongside Botswana and South Africa are the only three countries that operate a non-contributory social pension scheme in sub-Saharan Africa. In Namibia all, those aged over 60 years receive a monthly pension of N$500.00 once registered by the Ministry of Health and Social Service.

Income generating activities, the harvesting of natural resources and in a few cases livestock keeping were also found to be significant. With the deepening of the HIV and AIDS epidemic in Namibia, household livelihoods in rural areas have been severely affected. Ellis (2000) suggests that rural livelihood diversification is process by which rural households construct increasingly diverse activities and assets to survive and improve their livelihood. Although cropping was found to be the main livelihood activity and all the interviewed households practiced it, the study also revealed that the affects of HIV/AIDS on livelihood, specifically crops were being compound by natural disasters and in particular the flooding which has occurred in Namibia for the past five years. Of the elderly headed households questioned 65% indicated that they utilize their pensions as their main income source. The reason for this was stated that at the end of the harvest season the households found that they do not yield enough crops to last until the next cultivation season. The households with non elderly heads expressed similar sentiments. It was found that as result of the low yields they were receiving from their fields which were damaged by flooding that orphan foster grants were often now their main source of income.

6.3 Caring for orphans illness and death in affected households

In the households studied in this research the number of orphans has increased as has the number of sick people. However the study also reveals how illness and/or death related to AIDS has affected the livelihoods of these households. In these households mortality (10%) and morbidity (25%) are compounded by floods (50%) that have destroyed crops, this has contributed to increasing poverty and food insecurity. The results of this research show that households spend a considerable percentage of their income on food and school fees. A study by Sporton, (2007) found that affected households in Namibia often spent an “exorbitant” amount of money on hospitalization for those infected. In this research it was found that as the government of Namibia has made free the provision of medication to the elderly and for people infected with HIV/AIDS this cost has been reduced. Households only really spent money on transport fees to collect ARV for those households that were not within easy distance of a health centre. *According to the Children on the Brink (2000*), “One measure of the massive social change yet to come as a result of the global HIV/AIDS pandemic is the number of orphans, children affected by HIV/AIDS, and other vulnerable children. An estimation of 34.7 million children under age 15 in 34 who have lost their mother, father, or both parents to HIV/AIDS related deaths. A recent report by UNICEF, also estimated the number of orphans between 143 million and 210 million worldwide. Children on the Brink (2000), further indicated that the world without AIDS, the total number of children orphaned would have declined by 2010, to 15 million.

6.4 Livelihood strategies of affected households

This study reveals that few households in the study area had families who had migrated to urban regions and those who did migrate were often driven by the search for a job, for schooling or to care for a different household rather than because of a specific shock. The majority of households studied did not sell assets as a coping strategy; this was in part because few indicated that they had any assets to sell. The exceptions to this were two households, one in which a store was sold following the death of a husband, and another which sold livestock when cash was needed. This research finds in agreement with research that done by the World Bank confronting AIDS, indicates that households respond to the impacts of HIV/AIDS and other shocks by altering the composition of the household, by selling assets, and by utilizing assistance from other households and from informal rural institutions. Similarly, Ellis, (2000) describes migration as another response to these kinds of threat. Migration is used as a livelihood strategy by rural households with people sent off to urban areas for employment to increase income in the form of remittances.
In addition the World Bank indicated a change in the composition of households is an important way in which such households cope with shocks. The study reveals that most of the households in the study area also cope with shocks through assistance from their neighbours (40%), help from extended families, and in some instance support from home based care volunteers. Some households mentioned food aid provided by the government to households affected by floods as a source of relief and support; others suggested this food aid had never been given to them. Social support is important to rural households and communities. It provides hope to those who are vulnerable, and enables them to sustain their livelihoods. Social capital can come in the form of emotional support, financial support, or care support provided by neighbours or extended relatives.

6.5 Impact on livelihood and coping of households affected

The impact of HIV/AIDS on interviewed households varies and is determined largely by the assets available to them. This study has shown that the primary shocks and stress within the vulnerability context of the households studied in this research are mortality and morbidity related to HIV/AIDS and flooding. Mortality and morbidity lead to a reduction in household activities, less cultivation of fields, and a reduction in income. These problems are compounded by a greater need for food amongst those who are sick and the ever present threat of flooding which can destroy crops and lead to food insecurity. The local institutions that are supposed to respond to these shocks and assist households in coping with them are limited with few resources and insufficient capacity. Home based care volunteers play a significant role in helping households cope with these issues, as do local social networks of neighbours and extended families. This study shows that even though formal government social support in some areas has been reduced, strong social capital remains in these areas helping households to address these issues. Most of the households studied in this research also relied on elderly pensions and orphan grants not only for their livelihoods but in the event of a shock as a safety net for the household. While most of the households studied are at present able to cope with illness or death related to HIV/AIDS, their livelihood outcomes are increasingly precarious and under pressure particularly as a consequence of the recent flooding which has affected the region.

Chapter 7

Conclusion and Recommendations

7.1 Conclusion

The HIV/AIDS epidemic in Odibo village has changed rural livelihoods and the social structures of households. There is an increasing problem of dependency in rural communities which are becoming ever more reliant on pensions and orphan grant support. The majority of households interviewed in this research are headed by elderly pensioners who are now being forced to play an increasingly active role in providing for the sick, in caring for orphans and to make a living for themselves and their dependents. The 85% of households uses orphan grant in the study area as one of the main source of income to respond to the impacts brought about by illness related to AIDS and flooding in the region. While most households still practice livelihood activities of cropping, these activities have been altered by illness and by flooding with households no longer able to harvest enough crops to sustain them until the next rainy season. There are strong social capital linkages amongst households in the study area for this research. Assistance from neighbours is indicated to play an important role as a coping strategy for many of the households who otherwise would have no means of livelihood.

Most of the households spent a considerable portion of their income on average of N$500 on food. The expense of medication has been reduced in most households, with medication now free for the HIV infected people and elderly pensioners. Of the orphans that have lost one or both parents the majority in the study area have been registered and are in receipt of their grant. In a few households there were orphans that were not registered, this was because their fathers were unknown resulting in outstanding documents.

It was found that few household's members in the study area had migrated to urban areas in search of employment. This was not really found to be a coping strategy despite the findings of other studies.

There were few differences in asset ownership between male and female-headed households, apart from male-headed households spending more on the food compared to female-headed ones. Most of the households indicated that they had never sold any assets and that they had few to sell anyway.

In this study it was found that mortality and morbidity as result of HIV/AIDS was not the only shock faced to the livelihoods of households. The stresses associated with HIV/AIDS were compounded by the threat and impact of flooding. Flooding had to varying extents destroyed the crops of all of the households in recent years, reducing production and increasing food insecurity and vulnerability.

7.2 Recommendations

- Each village could set up a social fund to assist those households most severely affected.
- Strengthen the home based care volunteers
- Office of the councilor of the constituency in collaboration with home base care to involve affected households in income generating activities for income and food.
- Provide food aid as a short-term intervention for affected households.

8. References

ADB, 2006. Addressing African Middle Income Challenges-Current ADB Strategy and Further Reflections for Improvement.

Central Bureau of Statistics, 2001. Namibia Population and Housing Census. National Planning Commission. Windhoek Namibia

Central Bureau of Statistics, 2008. Namibia Population and Housing Census. National Planning Commission. Windhoek Namibia

Children on the Brink, 2000. www.unicef_childrenonthebrink2000/enpdf. (Accessed 21 August 2011)

Conway, G.R and Camber, R, 1992. Sustainable rural livelihoods: practical concepts for the 21st century. IDS Discussion paper, No 296. Brighton: institute of development studies.

De la Torre, C., et al, 2008. HIV/AIDS in Namibia: Behavioural and Contextual Factors Driving the Epidemic, Measure Evaluation, Macro International. INC.

Department for International Development, 1999. Sustainable Livelihoods Guidance Street: Introduction: htt://www.livelihoods.org/info/info-guidancesheets.html#1

Du Preez, C, 2010. Living and care arrangements of non-urban households in Kwazulu-Natal, South Africa in the context of HIV and AIDS. PhD Thesis. Wageningen University.

Edwards-Jauch, L, 2010. AIDS and Family Structures. Department of Sociology, University of Namibia.

Ellis, F, 2000. Rural livelihood and diversity in developing countries. Oxford University Press.

Harvey, P, 2003. HIV/AIDS: What are the Implications for Humanitarian Action? A Literature Review, London: ODI

Kristofferson, U. 2003. Security and Humanitarian Response (SHR). Interaction between the agricultural sector and the HIV/AIDS Pandemic: Implications for agricultural policy. ESA working paper, 4 (6) 1-39.

Leones, J.P and Feldman, S, 1998. Nonfarm Activity and Rural Households Income: Evidence from Philippine Microdata, Economic Development and Cultural Change, Vol. 46, No. 4, 789-806

Loevinsohn, M. and Gillespie, S, 2003. HIV/AIDS, Food Security and Rural Livelihoods: Understanding and Responding, Renewal Working Paper 2, Washington: IFPRI

Ministry of Labour, 2009. Republic of Namibia. Windhoek. Namibia.

MOHSS, 2004. Report of the 2008 National HIV sentinel survey. HIV prevalence in pregnant women, biannual surveys 1992-2008, Namibia. Directorate of special Programmes. Windhoek. Namibia

MOHSS, 2008. Report of the 2008 National HIV sentinel survey. HIV prevalence in pregnant women, biannual surveys 1992-2008, Namibia. Directorate of special Programmes. Windhoek. Namibia

MOHSS, 2010. Report of the 2008 National HIV sentinel survey. HIV prevalence in pregnant women, biannual surveys 1992-2008, Namibia. Directorate of special Programmes. Windhoek. Namibia

National Planning Commission, 2001. Republic of Namibia. Windhoek. Namibia

National Planning Commission, 2008. Republic of Namibia. Windhoek. Namibia

Niehof, A, 2010. Presentation notes, Wageningen University

Nombo, C.I. 2007. When AIDS meets poverty, Implications for social capital n a village in Tanzania. PhD thesis. Wageningen University.

O'Donnell, M. 2004. Food Security, Livelihoods and HIV/AIDS. A Guide to the Linkages. Measurement and Programming implications. London: Save the Children UK.
SADC, 2008,

Saith, A. 1992. The Rural Non-Farm Economy: Processes and Policies. Geneva: ILO, World Employment Progamme.

Scoones, I, 1998. Sustainable Rural livelihoods: A framework for Analysis, IDS Working Paper, N.72.

Shannon-Stokes, C, 2003. Measuring Impacts of HIV/AIDS on Rural Livelihoods and Food Security, Rome: FAO

Sporton, D. 2007. Population Ageing and Sustainable Livelihoods in regions affected by HIV/AIDS: Full Research report ESRC End of Award report, RES-000-22-1427. Swindon: ESRC

Topouzis, D. 2003. The impact of HIV/AIDS on Rural Food Security, SCN News, No. 17, December 1998, p. 20.

UNAIDS, 2010. Report on the global AIDS epidemic, Geneva. UNAIDS.

UNAIDS, 2009. Report on the global AIDS Epidemic. Geneva: UNAIDS

UNDP, 2001. United Nation Development Programme Report of Namibia.

White, J and Robinson, E., 2000. HIV/AIDS and Rural Livelihoods in Sub-Saharan Africa. Policy Series 6. Chatham, UK: Natural resources Institute.

WHO, 2002. World Health Organization Report on Namibia.

Wieger, E, 2004. HIV/AIDS, Gender Inequality and the Agricultural Sector: Guidelines for Incorporating HIV/AIDS and Gender Considerations into Agricultural Programming in High Incidence Countries. Ottawa: ICAD.

World Bank, Shifting Confronting AIDS.OP. CIT

9. Annexes

9.1 Survey Questionnaire

Household characteristic

Household No.: ……Gender household head……..

Type of Dwelling:…… Gender of the respondent……..

Family structure: …… Household size……

No	Relation to the head	Age	Gender Male=1 Female=2	Schooling(yes/No) Yes=1 No=2
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

1. Has the number of household member increased/decreased (yes/No)
    - Increased
    - Decreased
    - Unchanged
2. Explain what caused this

    ……
    ……
    ……
3. Have you loss a supportive family member/s?

Yes

No

4. What kind of supports did s/he/ they contributed to the household? (specify)

……
……
……
……..

5. Do any of the family members suffer from long illness?

Yes

No

If, yes what effect does it have on the household livelihood?

……
……
……
……
……..

Financial capitals

6. Livelihood activities	**Yes=1 No=2**	**Estimate monthly (N$)**	**Importance**
Crop production			
Livestock sale			
Crop sale			
Formal employment			
GRN Grant (old age)			
GRN Grant (Orphans)			
Foods aid			
Indigenous food products (specify……)			
Others			

7. Has there been any change in your livelihood strategies due to illness or death of household member?
   Specify……..

8. Estimate your monthly budget you spend on

- Food ☐ Clothes ☐ Other Specify ☐
- Hospital Fees ☐ School Fees, ☐

9. Was there a change in the household's sources of income as a result of the illness or death?.....
   .....
   .....

10. Which expenses are affected?.....

11. Have you sold productive assets (such as livestock, land) to pay for expenses and which expenses?
    ……
    ……
    ……

12. Which assets are likely to be sold first if household needs money?.....

13. Which expenses in your household budget are abandon when your household cannot meet all the needs?
    …….

14. What are the biggest expenses that your household has to meet?
    ……
    ……..

15. If you cannot pay for these expenses what is your alternative as household?.....

.....
.....

Social capitals

16. What kind of support do you receive within your community?
17. Who do you turn to for support when you are difficult times such as death or illness?
18. Do you care for children in these households whose parent/s has passed away and how do you sustain this children?
19. Do you receive food aid and who supplier you with food aid?
20. How often the household get food aid?
21. Have any of your household members migrated to other areas in the last twelve months and why?
22. How often did household's members migrate in the last twelve months and which sex is likely to migrate and why?
23. Do you require more labour now or less for cultivation of the crops in the household and why?
24. What factors contributing to change in livelihood strategies

Physical/Natural capitals

25. What type of livestock your household own?

Goats	Chicken	Pigs
Cattle	Donkeys	Sheep

26. How often do you sell livestock?

Never	Monthly	A few times a year
Only when need cash		Other (specify)

27. Why do you sell livestock?

28. What type of crops does your household grow?
29. In the last two years is your cultivation size still the same, if not why has the size change?
30. What effect does illness and death has on the cultivation of land?
31. How do you plough your fields?
32. In the last two years have you hire labour for cultivation and why?
33. What other assets does your households own?
34. Do you practice the same livelihood activities and have any of the activities changed in the last five years and why?
35. What most affects your livelihood activities in the last two years and how often?
36. Which activities did they affect and how did you overcome this?

9.2 Key informants questionnaire

1. Name
2. Organization
3. The nature of work they do, roles and responsibilities
4. What support does your organization provided to the AIDS affected households?
5. What are the impacts of AIDS at households level and how does you organization response to the situation to mitigate the impact?
6. Which household in terms of gender is most impacted by AIDS? Why?
7. Which other organization you work hand in hand to response to HIV/AIDS?

8. What are the challenges brought by HIV/AIDS at the households?

9. What are the challenges faced in working with AIDS affected households?

9.3 Pictures of respondents