

Gender, social capital and social reproduction: The (in)visibility of care work in the context of HIV/ AIDS

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Abstract

In Namibia the majority of orphans and vulnerable children are absorbed into the extended family structure. Out of an orphan population of 150 000 only a small number (729) is taken in by the 36 registered Residential Child Care Facilities (RCCFs) and 533 by unregistered RCCFs. There is, however, little discussion on who in the extended family does the caring or the gendered nature of that care. Women are the primary care givers of orphans and vulnerable children. This socially necessary reproductive labour is not enumerated or remunerated. The majority of households that take in orphans and vulnerable children are headed by elderly females who themselves depend on social transfers and remittances. The additional care burden exacerbates the crisis of social reproduction in affected households. Social Capital theorists, see women's social reproductive labour as instrumental to reducing the care burden on the state. Feminist Social Reproduction theorists see it as contributing to social inequalities. Research in Namibia reveals the crises of social reproduction in AIDS-affected households. This includes food insecurity, income insufficiency and the exclusion from services. Many affected households cannot access the social grants available due to social, economic and administrative barriers. This paper argues for the validation of women's unpaid social reproductive labour in order to break the cycle of poverty and marginalization caused by AIDS. It argues for the inclusion of unpaid care work into macro-economic frameworks.

Introduction

Feminist calls for the remuneration of women's social and biological reproductive work become more and more relevant if one considers the care burden HIV/AIDS has forced upon women. This work receives little acknowledgement on the part of governments, donor agencies and society at large. In fact, this lack of acknowledgement is so pervasive that it becomes almost invisible. Social Capital and Social Reproductive theories can help us conceptualise the social and policy issues implicated in HIV- related care work. Social Capital theorists see unpaid voluntary work as key to overcoming anomie and building social solidarity. This unpaid family and community care work, referred to as social capital, harnesses women's unpaid labour for the well-being of the family, the community and society. This valuable and socially necessary non-market care work at the same time reduces the costs of the care burden on the state. Feminist economists and Social

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Reproductive theorists look at the social inequalities that this care work produces and reproduces. They insist that women's increased workloads in the care economy should be valued, enumerated and remunerated to achieve distributive justice.

AIDS mortality interfaces with high levels of poverty. Consequently, some of the pre-existing child-care patterns in familial groups are intensified and others are disrupted. The tendency of poor families towards matrifocality is intensified as female members of the family group carry the bulk of the care burden. Often, men migrate or, for socio-cultural reasons, do not consider care work as part of their responsibilities. Questions of the gendered and unequal distribution of care work are seldom addressed in policy discourse, yet they have implications for gender equality and women's empowerment.

Social obligations, moral imperatives and cultural norms make women's involvement in care functions seem natural. However, matrifocal families or female-headed households who take on the biggest care burden as a result of AIDS-related morbidity and mortality struggle to cope. This is often seen as a crisis of reproduction because households and families struggle to reproduce themselves. Some households dissolve, some members of the household may migrate and others continue a socially marginalised existence through poverty, stigmatisation and exclusion.

Over the last few years, Namibia has experienced declines in HIV prevalence, rates of new infections and AIDS-related mortality. Despite the impressive progress made in the preservation of life through prevention of mother-to-child transmission (PMTCT) and antiretroviral access programmes, HIV/AIDS remains a development challenge and a threat to the social reproduction of families and households that take in orphans and vulnerable children (OVCs). This article focuses on the gendered nature of care, its policy implications and the social reproduction crises that accompany the increased care burden.

HIV and AIDS in Namibia: An Overview

Since HIV testing started in 1992, Namibia has made a lot of progress in the prevention, treatment, care and support to HIV/AIDS-infected and affected persons. The epidemic peaked in 2002 when a 22% HIV prevalence rate was recorded amongst pregnant women visiting state-provided antenatal facilities (Republic of Namibia, 2012b). The Namibian epidemic is maturing, which means HIV prevalence is not increasing or decreasing substantially (Kisting, 2012). The overall HIV prevalence amongst pregnant women is 18,2% (Republic of Namibia, 2012a) and prevalence in the general population is estimated at 13,5% (Republic of Namibia, 2012b). Although statistics cited may differ, there is a general consensus that the number of new infections has declined significantly (UNAIDS, 2012 & Republic of Namibia, 2012b). Declines in morbidity and mortality are attributed to the roll-out of antiretroviral therapies and a very effective prevention of mother-to-child transmission programme (PMTCT). Therapy coverage for the prevention of mother-to-child transmission is set at 97% and Highly Active Retroviral Therapy (HAART) coverage is 87% for children and 81, 5% for adults (Republic of Namibia, 2012b). While AIDS still accounts for 18% of all deaths in Namibia (ibid.), the number of annual deaths attributed to AIDS decreased from 10381 in 2002/3 to 5047 in 2011/12, a decrease of over 50 % (Smit, 2012).

The progress made in preserving the life of HIV positive persons is impressive. This will ease the devastating effects AIDS-related morbidity and mortality has on families, particularly OVCs. HIV/AIDS, however, still remains a public health concern as there are still an estimated 189 000 persons living with HIV (Republic of Namibia, 2012b). Key drivers of

the epidemic remain: multiple and concurrent sexual relationships, inter-generational sex, transactional sex, inconsistent condom use, alcohol use and abuse, population mobility, gender inequality and income inequality (Republic of Namibia, 2012b).

While there have been declines in prevalence amongst women in the 15-24 year age groups, peak HIV prevalence has moved to older age groups, namely, the 30-34 year age group (30,8%) and the 35-39 year age group (33.9%) (Republic of Namibia, 2012a). This shift is as a result of the decline in death rates, which means HIV positive persons are living longer. It can also be an indication of new infections in these groups (Kisting, 2012), or of non-condom use by married people or people in stable relationships (Nyangove, 2013).

While overall prevalence has declined in certain geographic areas, it remains persistently high in some of the northern parts of the country, with Katima Mulilo at 37,7%, Ohandjokwe 25,7%, Oshikuku 24,7% and Rundu 24,5% (Republic of Namibia, 2012a). The number of new infections remains a matter of great concern (Nyangove, 2013). A large portion of new infections is amongst young women of reproductive age (Republic of Namibia, 2012b).

Gendered nature of OVC Care

The latest population census statistics set Namibia's orphan population at 150 000 (Namibia Statistics Agency, 2012a); this excludes non-orphaned vulnerable children. The total number of orphans and vulnerable children is estimated to be around 250 000 (Republic of Namibia, 2012b). Women are the primary caregivers of these orphans and vulnerable children (*ibid*). The 2011 Population Census Statistics indicates that 13% of Namibian children have lost at least one parent and 2.7% have no parents. The highest percentage (17%) of orphans is found in the northern regions of Ohangwena, Omusati and Oshana. The number of orphans in rural areas is almost double compared to those in urban areas (Namibia Statistics Agency, 2012a). The majority of OVCs are taken up in family structures. Out of an orphan population of 150 000 (*ibid.*), only a small number (729) is taken in by the 36 registered Residential Child Care Facilities (RCCFs) and 533 by unregistered RCCFs (Republic of Namibia, 2012b).

Female-headed households (FHH) are more likely to take in OVCs than male-headed households. Generally, the burden of care rests disproportionately on older women in Elderly Female-Headed Households (EFHH), in short the grandmothers (Sporton & Mosimane, 2006). In many of Namibia's matrilineal communities, children are taken in by the maternal kin, more likely the maternal grandmothers, sisters or aunts. Often elderly female household heads in rural areas care for a number of OVCs from the extended family network. They could be grandchildren, great grandchildren, children of sisters, brothers, the grandchildren of brothers and sisters, children of cousins, or the children their deceased or absent husbands had with co-wives (Edwards-Jauch, 2009). In urban areas, it is done by younger women. Edwards-Jauch (*ibid*) found that 70% of AIDS-affected female household heads were caring for non-biological children in the rural areas.

HIV/AIDS and the care economy

The fact that primarily women do the care work is presented as natural. This work is unpaid and un- or undervalued but essential to the reproduction of individuals, families, communities and indeed, society (Folbre, 2012). In the literature, this reproductive work is often referred as the Care Economy. The Care Economy involves the provision of "non-market" work. In the context of HIV/ AIDS, this unpaid work includes the psycho-social support (emotional and spiritual), custodial care (cooking, cleaning, feeding etc.) and clinical care (ministration of medicines) (Odgen, Esim & Grown, 2004).

The crucial point for feminist sociologists and economists is that women's unpaid labour in the care economy is taken as a given. No attempt is made to enumerate the value of that work or to compensate it in monetary terms. This amounts to the exploitation of female labour. Unpaid and unvalued female labour reflects the gendered division of labour and the unequal power relationships of patriarchal societies. Those with the least resources (FHH) take on the burden of care, which reduces incomes and increases expenditure. For feminists, this raises crucial questions of distributive justice (Folbre, 2012).

In the context of HIV/AIDS this work is largely done by female family members and female community volunteers, who form part of an army of home-based care workers and lay counsellors, who provide crucial services to HIV-infected and affected people. In some subsistence agricultural economies of rural Namibia, it includes household food production as well as water and fuel wood collection.

Despite government social transfers to and remittances from extended family members, these households face severe resource constraints (Sporton & Mosimane, 2006). The Namibia Household Income and Expenditure Survey (NHIES) 2009/10 (Namibia Statistics, 2012 b) points to the poverty that affects children in Namibia. Thirty four percent of children grow up in poor households. Children who grow up in households that take in orphans and are headed by females are more at risk of being poor (ibid.).

The causal linkages between poverty, inequality and HIV/ AIDS are at the centre of the AIDS crisis of social reproduction. Poor people carry the largest burden of impact mitigation, which is often transferred from the state and business enterprises to poor households. Poor households lack resources and are less able to absorb the impact of HIV/ AIDS. Poverty increases the incidences of transactional and intergenerational sex. Women and girls from poor households, at times use, sex as an economic survival strategy. This, in turn, makes them vulnerable to HIV and AIDS. Often this cycle of poverty, inequality and HIV-related vulnerability is reproduced across generations (Edwards, 2004).

Conceptual frameworks for understanding the gendered nature of care and its policy implications

Social Capital Approach

Sociologist Pierre Bourdieu (1986) adapted the Marxist theory of capital to arrive at a more differentiated and multi-faceted approach to capital in an attempt to overcome economic reductionism. This multifaceted approach emerged as an explanation of the differential access to resources and hence the differential educational outcomes children from different social strata face. He argued that in the process of social reproduction humans acquire, transmit and reproduce cultural, symbolic and social capital. He identified social capital as "the aggregate of the actual or potential resources which are linked to the possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition" (Bourdieu, 1986, p. 249). The networks that constitute social capital are socially constructed through affinal, conjugal, friendship, class or community ties and are used to extract mutual material or symbolic "profits" (ibid.). In other words, these ties or social capital can be invoked to overcome difficulties or gain access to resources. These ties are not always tangible. They include beliefs and cultural practices, like human relationships, obligations, norms and forms of reciprocation (Fine & Lapavistas, 2004).

To Bourdieu (1986), social capital is strongly linked to the political economy of social reproduction and the person's objective social location. Therefore the volume of social capital a person is able to mobilise depends on the size of the networks of connections and the volume of economic, cultural and symbolic capital accumulated within those networks. It thus follows that the social capital available to a rich person is much larger than to a poor person, because relations and networks of reciprocity and solidarity depend on the recipient's ability to also exchange his/her own resources in turn, so that, in the final analysis, social capital has its roots in economic capital.

Since Bourdieu the social capital approach was adopted and adapted by a number of social theorists in different disciplines, sometimes in stark contradiction to Bourdieu's initial theorisation and at times with a very conservative bias (Molyneux, 2002). A narrower definition of social capital formation comes from Putman (1995) who argues that social organisations and networks based on norms and social trust can facilitate co-ordination and cooperation for mutual benefit. From a more conservative communitarian position, Putman (*ibid.*) laments the erosion of social trust and connectedness which he links to the increased entry of women into paid work (labour market participation). This decreases the availability of women for unpaid family and community work and hence, the volume of available social capital.

Coleman (1988) takes a more economic view of how social capital can be employed for more productive purposes, despite its existence in less tangible relations (culture, customs, trust, norms) amongst people. The moral and social obligations linked to reciprocity can thus be harnessed for economic gain (Schmid & Robinson, 1995). This notion of social capital found its way into the development discourse and policy debates primarily through the World Bank. The World Bank sees it as the "missing link" in sustainable development. In this vein, Grootaert (1998) argues that the networks, norms and obligations implicit in social capital formation could be used to promote economic growth, equity and poverty alleviation. She points to examples where social capital was used to overcome market failure or the collapse of state provided social services.

The World Bank (2011) lumps together an array of institutions it sees as key sources of social capital, namely, families, communities, firms, civil society, public sector, ethnicity and gender. This view has provoked a lot of criticisms from, particularly, feminist social theorists who argue that women's unpaid work is by far the largest contributor to social capital stock and while women's unpaid labour contributes to the greater good of society, it is seldom acknowledged in macro-economic policy making or in the national accounts. This makes women's work seem invisible.

On the one hand, social capital theory brings into focus the norms and values that underlie human solidarity, social cohesion and community participation. On the other hand, it ignores social inequalities in the family, communities and society. Molyneux (2002) argues that social capital can act as a counter-weight to anomie, since it activates greater community participation in development and restores the "social" to economic thinking. On the down side, gender is absent in troubling ways from the social capital debate.

Critical voices on the social capital debate argue for the inclusion of social stratification, inequalities and power differentials into the analytical framework (Fine, 2001). From a feminist perspective, Straveren (2002) argues that the concept of social capital should take into account the gendered division of labour and gender power differentials in the family and in the community. A key solution would thus be to redistribute some of the unpaid labour time, crucial to the creation of social capital from women to men, thus elevating men's role in the formation of social capital. Social capital is created out of formal and informal associations between people, starting with the family, then moving to neighbourhoods, local communities, then political and voluntary organisations. Social capital also encompasses multiple points of social stratification, like "race", ethnicity, social class, region, nationality and gender (Fine & Lapavistas, 2004). These systems of social stratification are often based on unequal relations of power and unequal access to resources. Thus, depending on social location, the accrual of and access to social capital is unequally distributed in society (Molyneux, 2002). Due to this unequal distribution of social capital, inequality is further reproduced.

In the context of AIDS-related OVC care, the most important and immediate stock of social capital resides within the extended family networks. The size and volume of social capital available depends on the social location of their families and communities, within a broader stratified social structure, in terms of class, "race", ethnicity, gender and age.

Changes in family structure can lead to deficits in social capital (Edwards, Franklin & Holland, 2003) HIV/AIDS-related morbidity and mortality change family structures, in terms of form, size, composition, division of labour, stability, income sources and intergenerational transfers (Edwards-Jauch, 2009). A crucial point for policy-makers is, therefore, how to off-set these deficits in social capital available to OVCs, otherwise the differential and unequal volume and quality of social capital they are able to access will reproduce inequalities, social and economic marginalisation (Edwards, Franklin & Holland, 2003).

Feminist Social Reproduction Theories

Social reproduction is a process through which individuals, families and indeed an entire social system reproduces itself (Randriamaro, 2013). At household and family level, it includes activities related to the reproduction of inequalities and poverty that, in turn, reproduce vulnerability and susceptibility to HIV and AIDS (Bujra, 2004). Social Reproductive Feminists (SRF) see care work as social reproductive work and argue for an expanded notion of production to include social reproduction, as it is crucial to the functioning of the economy and a prerequisite for production. This is premised on the insight that daily human needs exceed the purview of the formal paid labour and largely depends on the informal unpaid, but socially necessary labour (Barbagallo & Federici, 2011; Ferguson, S., 2008). The call is thus to end the artificial separation of productive and reproductive labour, as social care is essential to human life and well-being (Ferguson, 2013). Such insights have implications for how employment and unemployment are viewed. Often women who perform this socially necessary unpaid reproductive labour are seen as unemployed or euphemistically called home-makers, along the dictum "she is not working; she is at home", which implies that women's work is no work.

SRF firmly posit the gendered and unpaid nature of reproductive labour within the dominant patriarchal capitalist ideology and political economy. The division between market and non-market labour ignores the interdependency of capitalist and non-capitalist

aspects of the economy (Ferguson, L., 2013). The SRF critique of the partial representations of what constitutes economic activity has led to a critique of how gender equality is viewed within the dominant development policy discourses. These dominant discourses as posited by the World Bank and other agencies show contradictory tendencies. On the one hand, they pursue women's empowerment, on the other, they tap into the unequal gender power relations to mobilise women's unpaid social reproductive work to achieve poverty reduction targets (Molyneux, 2002 & Ferguson, 2013). The rationale is often to reduce the care burden on the state. Not only are such policy directives lodged in the dominant relations of inequality, they also reproduce them (Ferguson, 2008).

SRF see the struggle for society's recognition of reproductive labour as at the heart of the struggle for social change. They call on society to allocate and distribute resources in recognition of this labour through the provision of a social wage for this reproductive labour (Barbagallo & Federici, 2011). A crucial point to remember is, as female migration from rural areas to the cities increases, the burden of reproductive labour falls disproportionately on those who may be dependent on others for their own survival, that is, female pensioners (Folbre, 2012).

OVC care policy frameworks are based on the premise of the exploitation of women's unpaid social reproductive labour. Namibia's current OVC policy frameworks see OVC care as the primary responsibility of families (Republic of Namibia, 2004). This follows traditional cultural practices, but in reality it means the responsibility rests with women in the family.

Fostering and caring for children within the kinship group has been a longstanding practice even before the AIDS epidemic. Adoption or fostering within the extended family, however, takes on another dimension with AIDS mortality, as the element of voluntarism is eroded. Extended family members feel obliged to take OVCs because custom and tradition places those responsibilities on the kinship group. This type of coercive adoption and fostering could result in difficult relationships, discriminatory treatment and abuse (Ansell & Van Blerk, 2005).

The crisis of social reproduction in AIDS affected families and households

HIV/ AIDS-related morbidity and mortality present a crisis of social reproduction in affected families and households. In Namibia, the areas with the highest prevalence rates also absorb the largest care burden. The biggest impacts at household level are losses in labour supply, losses in income and increases in expenditure. These in turn affect other factors, most notably, increased levels of poverty, food insecurity and the ability of a household to reproduce itself. This may then lead to stress migration, household dissolution, recomposition and increased dependency ratios (Edwards-Jauch, 2009).

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

Income loss includes reductions in household food production, reductions in the sale of agricultural produce and crafts, loss in wages or loss in remittances from household members or members from the family or kinship group (Jackson, 2002). There are significant differences between the economic position of households affected by HIV and those that are not affected. These differences relate to changes in income, consumption and savings (Van Liere, 2002).

Increased food insecurity undermines women's autonomy and contributes towards risky behaviour. Women are primarily responsible for household food supply and are, therefore, at times obliged to trade sex for food or cash. This means further risks of HIV transmission (Harvey, 2003).

AIDS mortality could have different impacts on different households. Some families may sell assets like livestock and draught animals to pay for increased expenditure related to illness and death. The impact is most severe rural small-scale farming communities where the decreased adult labour supply, and hence decreased agricultural production, and increased care burdens threaten the survival of the household (Mutangadura & Sandkjaer, 2009). In certain instances, people sell seeds, surplus food as well as land to compensate for their income losses. The sale of productive assets could lead to a further downward spiral in household income and further threaten social reproduction, as these assets are normally used to generate further income (De Waal & Tumushabe, 2003; Harvey, 2003; Barnett & Whiteside, 2006; Andrews et al., 2006). Households may also sell other items like radios, television sets, furniture, jewellery and clothing in a desperate attempt to obtain income (Barnett & Whiteside, 2006; Harvey, 2003). AIDS-related death in richer rural households could affect the income of other non AIDS-affected poorer households who rely on employment and, therefore, wages, transfers and remittances from richer households (De Waal & Tumushabe, 2003).

The absorption of OVCs by the extended family is not always benevolent. AIDS deaths generally lead to declines in household labour supply. There are instances where the adoption of OVCs is a strategy to compensate labour shortfalls. Boys are used for agricultural labour. (Harvey, 2003). Girls are used as a source of income and may, therefore, be married off in order to generate bridewealth/dowries (De Waal & Tumushabe, 2003; Harvey, 2003). Girls may also be withdrawn from school to compensate for the loss of female social reproductive labour, like child rearing, cooking and cleaning. However the adoption of OVCs can never completely offset the total loss in labour caused by adult morbidity and mortality (Mutangadura, 2005).

Rural women, particularly those in female-headed households (FHH) are responsible for household food supply as a result of the gendered division of labour and land allocation. The death of a female adult results in bigger decreases in grain production since women provide the bigger labour input into crop production. Harvey (2003) and De Waal and Tumushabe (2003) call this a double loss, for healthier women reduce time on food production in order to care for those who are sick or left vulnerable, like orphans. Households may lose up to two years of labour before the death of an HIV-infected person. The loss of labour, as a result of illness/inability to work, time used to care for sick persons and time taken to attend funerals, severely hampers output. A study in Uganda showed that women in AIDS-affected households spent zero time in the fields compared to the 60 hours of women in unaffected households (Van Liere, 2002).

There is a debate about whether households affected by AIDS are coping or surviving. De Waal and Tumushabe (2003) argue that the word “coping” is a misnomer since AIDS-affected households can seldom maintain or preserve a socially acceptable level of living.

In Namibia, various studies have documented the social reproduction crises that face, particularly rural HIV/ AIDS-affected households (Abate et al, 2003; Le Beau & Mufune, 2003; Ruiz- Casares, 2004 & 2007; Fuller & Van Zyl, 2006; Sporton & Mosimane, 2006; Project Hope, 2006; Thomas, 2006; World Food Programme, 2006; Namibia Red Cross Society, 2006; Legal Assistance Centre (LAC), 2007; Edwards-Jauch, 2009). All show that many affected rural households face food insecurity. The LAC study (2007) found that 71% of OVCs face food shortages. This famine, however, is not always very visible, for it does not affect entire communities but specifically HIV and AIDS-affected households. Often, only they and those in their social networks are aware of the problem (Fuller & Van Zyl, 2006).

The social reproduction of poverty and inequality in HIV/AIDS-affected families is affirmed by Thomas (2005) who points out that OVCs already come from families with a low resource base. She, therefore, argues that HIV/AIDS impacts should be understood in the context of multiple and co-existing vulnerabilities. Edwards-Jauch (2009) points to the social reproduction crises caused by AIDS-related mortality in the rural areas of Ohangwena region, namely, the decline in available labour, loss of remittances and loss of other forms of income.

State support for households that take in OVCs

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

In addition to old-age pensions, the Namibian social security net allows for other welfare payments like state maintenance grants to biological parent, if the breadwinner who receives other forms of welfare payments has died or is incarcerated for more than six months. There is also a Special Maintenance Grant for disabled children under the age of 16 and a Foster Care Grant for foster parents. Despite this Project HOPE (2006) found a 90 percent income insufficiency in households that host OVCs. This indicates that government transfers in the form of grants and pensions, if accessed, are simply not sufficient. The World Food Programme (WFP) Community Household Surveillance (CHS) (2006) study found that only 11 percent of the 73 households sampled received cash grants. This demonstrates a low uptake of non-pension grants. The LAC (2007) reports that only 8 percent of OVCs interviewed received the OVC grant. Sporton & Mosimane (2006) further found that between 73 percent of other households and 81 percent of elderly-headed households (EHH) did not receive any other form of assistance. Only between 4, 5 percent of EHH and 7, 5 percent of other households received child support grants. They concluded that the low uptake of child care and other grants may reflect the cumbersome registration procedures. This is corroborated by the Namibia Red Cross (2006) study in the Ohangwena Region that identified delays in processing grant applications and the lack of birth certificates required for registration as the biggest impediments to accessing grants. In addition to these, Edwards-Jauch (2009) found that low levels of literacy amongst

care-givers and lack of official (English) language skills added to the dilemma. Sporton & Mosimane (2006) show that only 4,5% of households received government child assistance grants due to a lack of information, low levels of literacy, lack of transport to government offices, time constraints due to other agricultural activities and difficulty in registering orphans for these grants.

Poverty threatens social reproduction and life itself. As a result of a decline in labour supply, some rural households face conditions of famine. The lack of affordable transport means that some cannot access medical treatment. Although education and medical treatment are theoretically free, there are still costs involved, like nominal contributions towards the school fund, school uniforms, cost of transport, payments at clinics and hospitals, food for sick relatives in hospitals, and costs of accompanying relatives to hospital. These costs place the services outside the reach of some poor HIV/AIDS affected households (Edwards-Jauch, 2009). In fact, the LAC (2007) study found 92% of OVCs could not access some or other service due to financial constraints.

To overcome the crises of social reproduction, Randriamaro (2013) calls for a new conceptualisation of unpaid care work and for its inclusion into macro-economic frameworks. She considers care work as exacerbating inequalities and that this should urgently be addressed as a matter of public policy. In addition, she recommends that a) there should be a recognition of the value of care work; b) a more equitable redistribution of that work between men and women, as well as between states, communities and families; c) a rethink of sites of social reproduction away from the privatised family space towards a socialised care system; d) a conscious decision not to have women and vulnerable groups pay the price of social reproduction. To attain the aforementioned, an alternative economic paradigm is needed, one that fully integrates unpaid care work to ensure adequate social reproduction.

Conclusion

AIDS-related mortality increases the poverty of affected families due to income loss, loss of labour, sale of future income-producing assets such as cattle, and increased expenditure due to illness and death. In addition, AIDS increases the dependency burden because fewer adults have to care for more children and sick people. The dire circumstances of affected households are reflected in stress migration, food insecurity, declines in food and agricultural production, and lack of money to access healthcare and other basic needs. Social transfers like pensions, maintenance and child support grants are not sufficient to overcome conditions of poverty. This presents a crisis of social reproduction, as affected households struggle to provide for the necessities of life and well-being. A cycle of susceptibility and vulnerability is created when children and women in families that have experienced AIDS mortality engage in risky sexual behaviour as part of their survival strategy.

The cause and effect relationship between HIV/AIDS and poverty produces a mutually reinforcing cycle. As poverty is transferred from one generation to the next, it reproduces susceptibility and vulnerability. It also reproduces social and economic inequalities, as already impoverished, female-headed households have to take on the additional care burden. The cycle of poverty and exclusion may, therefore, continue and bring about future generations of impoverished and socially excluded people, and susceptibility to new waves of HIV infection.

Social capital and social reproduction theories provide insights and ways of explaining the role of the care economy in the process of social reproduction. Policy makers are yet to acknowledge the value of the social reproductive labour women perform in the care economy. There are no attempts to enumerate and remunerate this socially necessary care work.

The HIV/AIDS care burden befalls those with the least resources, namely, elderly female-headed households. This is embedded in, produces and reproduces the gender and other social inequalities. To overcome gender inequalities and the crises in social reproduction, macro-economic frameworks should overcome binaries between market and non-market labour in order to acknowledge and reward the socially necessary reproductive labour carried out by primarily women in households and communities.

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