ABSTRACT
While kinship used to be considered a backbone of the creation of mutual obligations for care in pre-industrial societies, economic and social change has altered how care is provided. Notwithstanding changing kinship obligations, relatives continue to provide much of the care for those in need. In this article, I consider the active production of relationships among siblings through individual biographies, to understand how mutual obligations are created and affect the care provided to HIV-positive persons. I draw on two phases of ethnographic research conducted in Zambia, in Southern Province and Lusaka, between 2002 and 2011. Findings revealed that siblings are normally considered an important source of support, but their willingness and capacity to provide support may be limited by resource constraints and biographical experiences. Helping or not is at the conjunction of kinship-based obligations and a sense of connectedness, deriving from the history of growing up together, often in the context of disrupted families. The experiences of siblings in their past reach beyond individual histories. Structural factors jeopardise the support between and within generations, and must be addressed while promoting social protection programmes.

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During an interview on uptake of HIV-related healthcare services in a rural area in the Kafue Flats of Zambia, a young woman explained to me that she was about to leave her husband and move to her sister’s house for recovery. She had been sick for some time and had recently been diagnosed HIV positive. She had commenced antiretroviral therapy (ART), but her health was improving only slowly, and she was still too weak for the physically demanding work in the house and the fields. She was not receiving material support from her husband and therefore planned to move to the capital city, Lusaka, to live with her sister, who had agreed to look after her. It was generally a common practice to ask siblings for help in times of trouble.

Mobilising care and financial support during periods of illness is a key concern of persons living with HIV and their families, who carry the additional burden to provide for the sick person (Bond et al., 2003; Chileshe & Bond, 2010). Impoverishment due to health-related expenditure, while having a reduced capacity to work, is a corollary of poor health in settings with high out-of-pocket expenditures for health-care (Russell, 2004), resulting in food insecurity for many families affected by HIV as a result of income constraints (Young, Wheeler, McCoy, & Weiser, 2014). In Zambia, free ART is available (Ministry of Health and Community Development Mother and Child Health, 2013), but social protection programmes to compensate for illness-related income loss, such as nutritional support packages for vulnerable persons living with HIV, were inaccessible for many (Ministry of Finance, 2014; Ntalasha, Malungo, Merten, & Simona, 2015). Family members usually provide most of the HIV-related care work (Akintola, 2006), and persons living with HIV are often aware of the burden they impose upon their families (Bond, 2010). From the perspective of a sick person, mobilising family members for care and material support must therefore be carefully balanced between personal needs and the burden this may impose on others.

Social norms of reciprocity influence expectations of support by relatives. The anthropological literature on classificatory kinship structures distinguishes between matrilineal, patrilineal and bilateral institutional arrangements (Colson, 1958), which prescribe the degree of social intimacy between related persons from the patriarchal or matriline. Hitherto, kinship systems have predefined patterns of conduct (Berger & Luckmann, 1966, p. 72), providing a blueprint for mutual obligations.
between related persons, and embedding the individual in a specific rights setting, which defines access to material resources and social support (Berry, 1993; Meillassoux, 1978; Meyer, 1969; Sahlins, 1972). However, what can be expected through kinship relations is open to reinterpretation and renegotiation (Cliggett, 2006; Haller, 2013; Peters, 2010). Claims may be made on the basis of membership on either the maternal or the paternal side, or on the basis of marriage. Further, as much as kinship networks provide a basis for support claims, they may be refuted, and opportunities are additionally limited due to widespread poverty, directing claims towards a few (Haller, 2013). Empirical research in various African settings, in the case of HIV-related care (Gysels, Pell, Straus, & Pool, 2011; Moyer & Igonya, 2014; Niehaus, 2007), and in the case of food crises (Cliggett, 2006), has illustrated that neither marriage nor classificatory kinship need provide a secured and reliable social safety net. Often, support was only given if a direct return could be expected (Cliggett, 2003; De Jong, Roth, Badini-Kinda, & Bhagyanath, 2005; Haller, 2013). Especially poor people who were unable to invest in kinship relations were further marginalised (von Benda-Beckmann & von Benda-Beckmann, 2000; Cliggett, 2003, 2006; De Jong et al., 2005; Haller, 2013; Roth, 2014). Yet despite uncertainty, kinship continues to shape the perceived norms for mutual obligations, such as expectations of material support.1

The engagement with the body of a sick person is the most personal dimension of care, creating an intimate space between the sick person and the caregiver. Touching a body mediates notions of sociality and exchange, presuming kinship bonds, empathy or love as a premise for bodily care (Geissler & Prince, 2010). Bodily care realises intimacy and love as much as it can hurt and humiliate, and the shared history and experiences of the cared and the caregiver are the thin line that decide over intimacy or humiliation. Kinship prescribes who has to provide care to whom: taking continuous care of a relative is also a way of showing respect (Dilger, 2010).

In this article, I investigate the particular role of siblings in HIV care. The literature provides us with two major narratives around siblings and care: it either highlights the continuous care and support that brothers and sisters aim to provide to their siblings (Alber, Coe, & Thelen, 2013), or provides instances of neglect and withdrawal in the case of AIDS (Niehaus, 2007). Dilger (2010) reminds us that the success or failure of family to provide care cannot be understood merely in financial and material terms. Kinship shapes the significance of relationships of care between specific members of the family, defining in principle obligations and expectations (Dilger, 2010). While classical kinship studies focused predominantly on marriage and intergenerational relationships in pre-industrial societies, structurally driven changes in population dynamics allowed for a larger variety of living arrangements and social support mechanisms, influencing also the terms of kinship relations. Niehaus (1994) wrote already two decades ago about the increasing importance of sibling relations for household formation in early post-apartheid South Africa, which he interpreted as a response to conjugal instability associated with labour migration, common under apartheid and post-apartheid, and in Southern Africa in general. Roth (2014), who worked in Burkina Faso, also observed the increasing importance of sibling relations for social security in a West African society experiencing rapid economic change. An increasing number of youth-headed households in the context of the HIV epidemic further raised the awareness of the care, which is provided by siblings, often under most precarious conditions (Evans, 2012).

Below, I explore the experiences of siblings along the life course to understand how expectations of mutual support are shaped. I understand kinship as a web of pre-defined relations or social institutions with culturally specific expectations, which may guide but do not determine individual relationships. Attention must be paid to the fact that in various African contexts, the term sibling is not narrowly defined. Siblingship is not limited to shared parentage, and may extend to first and more distant cousins. Parentage in turn includes social parentage, in reference to those who raised the child but are not the biological parents. Alber et al. (2013) have distinguished three ways in which sibling relationships may be understood: as shared parentage, through shared experiences, and through continuous exchange and support. Accordingly, relationships must be analysed in terms of different experiences of relatedness.

Hence, my aim is to understand how mutual obligations are created among siblings, followed or rejected, and how these affect later relationships when relatives are in need of care. I discuss how specific rights and obligations linked to resources shape expectations for mutual support, and how interpersonal experiences may offset such expectations. The cases relate to care, or failure to care, in the context of HIV.

Methods

In this article, I draw on two phases of ethnographic research in rural Zambia (Namwala District, Southern Province and Lusaka) between 2002 and 2011, and on biographical interviews conducted in Lusaka in 2011. The first period of fieldwork was between 2002 and 2004, and focused on childcare, investigating social
support networks in families and communities during a food crisis. The second study took place between 2009 and 2011, investigating how social dynamics shaped access to HIV-related clinical care. Participant observation, life histories and interviews with people living with HIV about their experiences of social support provide the data for this analysis.

I understand life histories as narratives that allow insight into how a person interprets the past vis-à-vis the researcher, and how kinship relations are experienced over the life course when discussing the present life situation, even if these experiences may be told in different ways at different occasions. Denzin, citing Elbaz, reminds us that autobiographic narratives, such as life histories, are “narrative arrangements of reality” (Denzin, 2012). The story that is told by a participant may have a tactical component in order to legitimise past actions in a person’s life (Blanes, 2011) and, in this respect, I am not concerned that biographical information to examine past experiences of a person may be “unreliable”. One focus of the life histories was HIV, including how informants learnt about and managed HIV in their lives. Relatives figured as important persons in these narratives, whether they were affected by HIV or were providing or withholding support towards a person living with HIV. The perspective taken for analysis is one of tracing sibling relationships in terms of conflicts and support over the life course, as interpreted at the time of the interviews. I follow how claims for support by relatives were legitimised, how affection between siblings emerged over time or how it was destroyed by past experiences, in order to understand why particular support is provided or refused.

Participants were initially recruited through key informants in the study sites; some were community health workers or lay HIV counsellors. Written informed consent was obtained from all persons interviewed. The four case studies presented below were all based on biographies derived from several formal and informal follow-up interviews. Of these, three people had participated in both studies, and I engaged with them on a regular basis from 2002 to 2004, and 2009 to 2011; the other was contacted only for the study on access to HIV-related services in 2010. All four persons were living in the immediate neighbourhood where I conducted participant observation. I spoke English with some of the interviewees, whereas many other interviews were conducted in Cilla or CìTonga. We often discussed together the framing conditions of HIV, and my findings. All formal interviews were recorded and transcribed verbatim, while informal conversations were partly recorded and transcribed, partly written down in a notebook. In this article, narratives obtained from interviews were re-coded with AtlasTI V.7 in order to identify latent themes around the role of siblings for care and social support, with a focus on HIV-related care.

Ethical clearance was obtained from the Ethical Committee of the Cantons of Basel, the Central Board of Health, Zambia (first study), and the Ethical Commission of the University of Zambia (second study). In addition, permission of the Ministry of Health in Zambia was obtained.

**Ambiguities of care**

I began to think about the importance of sibling relationships in the context of HIV in response to a particular troubling experience. I was present when a sister withdrew support from her critically sick brother, and I had considerable difficulty understanding why this was so. I felt helpless. I did not know the sister well, but her brother had been an important informant and critical thinker during my earlier field studies. Before ART was widely available, Bond et al. (2003) had found that especially in conditions of poverty, relatives sometimes reduced the care that was provided to an AIDS patient when they expected that the person would die at any time. But about 10 years later, the situation had clearly changed: ARVs were widely available and recoveries were considered possible. This situation seemed different. The family, including the sister, was educated and not poor. I knew from my friend’s biography, however, that there were many difficult circumstances in his family, which had soured his relationships with several of his siblings. Following these biographical threads, below I introduce Carlos and his sister as the first example of how structural kinship is closely intertwined with conflict among siblings, leading to limited affection and little support.

**Carlos**

Carlos was a neighbour and a second cousin of our host, in the rural area where I had conducted my first and part of my second field research. When I met him first, he was in his late 20s. At that time I was interested in infant feeding practices and food security, and he participated as a key informant soon after he had married his third wife in 2004. In 2009–2010, he agreed again to participate in a biographic study, with a focus on HIV. I had quite regular contact with him and sporadically spoke also with his three wives. He had grown up in the rural area where I was working, the first son of one of the more influential cattle owning families. His father was married to his mother only, although the rate of polygyny used to be between 20 and 30% in the area (Merten & Haller, 2005). When Carlos was 4 years old, his
maternal uncle came and asked for Carlos to live with him, some 20 km away. In the Kafue flats, it was common for young boys to be sent to live with their maternal uncles, the achisha, with whom they often developed close relationships and eventually acquired the right to inherit; the power of maternal uncles was considered greater than that of the father (Smith & Dale, 1920). The kinship organisation of the Balla people used to be bilateral, which meant that people perceived themselves as flexibly belonging to both clans (Haller, 2013), although a clear distinction was made between the mukwash, the line of decent through the father, and the mukowa, the maternal line (Smith & Dale, 1920). Clan membership was used to mediate support in times of need, such as during food crises, as explained a century ago, by an informant of Smith and Dale, the colonial administrators: “The true clan is that which appears when you are in trouble, when you are bereaved or ill and a clansman comes to see you… they stand by your death and everything else that comes to you” (Smith & Dale, 1920, p. 295). This was still the case in the 2000s (Merten & Haller, 2009). In the rural areas of the Kafue Flats, where most income was still generated with small-scale farming and cattle herding, the organisation of kinship and families continued to be shaped by ideas of belonging to a clan that jointly managed access to land and other resources (Haller, 2013). Maternal uncles had a special importance among relatives, and bonds between nephews and uncles were strong, as was common among various groups in this region (Bloch & Sperber, 2002). In contemporary everyday life, maternal uncles still play an important role, and especially after a divorce or death of the father, maternal uncles often provided the resources for their sisters’ children (see also Colson, 1953, 1958). Maternal uncles were expected to pay cattle for the bride price when a young man wanted to get married, and they might give a nephew the right to use land or to use oxen for ploughing. In turn, they were recipients of a part of the bride wealth if a daughter of their sisters married. So Carlos stayed with his maternal uncle; he later sent Carlos to boarding school, and changed Carlos’s surname to his own name. When Carlos was in secondary school, his uncle gave him a land cruiser to use after school. Even though the uncle had other sons, he openly favoured his nephew. Carlos legitimised this by referring to the customary rules, stating that it was not uncommon to look for a heir within the mukowa, the maternal line (Smith & Dale, 1920). In contrast to his biological father, his maternal uncle was among the wealthier persons in the area. He owned over a hundred head of cattle at that time of this research, and three vehicles. Besides cars and maybe having a TV, most wealthy families however still followed a very traditional lifestyle. Homesteads consisted of several small houses around a yard, often made of clay, with the kitchen a covered fireplace in the middle of the hamlet. Carlos grew up in this “traditional” environment, while he went to school with his cousins. After completing school, he was expected to help the uncle on his farm: “[My uncle] said ‘I have taken you to school so that you’ll be able to read the medications for my cattle, so you’ll be my farm manager, you’ll be looking after my animals.” Carlos, who would have preferred to go to college, was obliged to stay with his uncle until he married. His uncle paid the bride wealth for his wife.

When Carlos was 27 years old, his uncle died. Immediately afterwards, the sons – Carlos’ cousins – supported by their relatives, claimed the properties of the father. According to customary rule, the uncle had intended to make Carlos the legitimate caretaker of the cattle and of other assets. Kulya ihini, “eating the name” of his uncle, theoretically endowed Carlos with all the powers of his uncle according to customary rules (Smith & Dale, 1920). Carlos stated that in his view, “traditionally nephews are more important [than sons], they are regarded to be very next to the uncle … [and are supposed] to inherit, because we inherit through the mother’s side.” However, Carlos’ cousins, the biological children of his uncle, and some of their relatives, disagreed, referring to the statutory inheritance law, which specified that only biological children would inherit. His cousins also had limited trust in Carlos as caretaker of the family wealth. Carlos disputed the legitimacy of this law: “Now that there is this law … I’d say western law, not African rules, now they are putting nephews aside and they are putting the sons in front.” It was a common concern that a single caretaker may benefit disproportionally, while other relatives would then no longer be able to benefit from the animals, which used to be an economic buffer that could be tapped in times of need (Haller, 2013). Hence, Carlos’ cousins took the car and all the animals, which the uncle had assigned to the nephew. Most of the animals were sold a short time afterwards, fuelling tensions between Carlos and his cousins: “My cousins, those sons of my uncle, they [sold] the cattle, this time they are just [poor] like me. They sold all the vehicles, they even sold the iron sheets which were on the roofs of the houses.” In the local inheritance system, assets and obligations used to be tied together, and the caretaker of the cattle was responsible for equitable distribution of the resources, directing them towards those in need. Cattle had been a buffer for times of shortages – it no longer was. This created considerable tension in Carlos’ family as many of his cousins found themselves impoverished within a short time.
Shortly thereafter Carlos fell severely ill for the first time. He was 35 years old at that time, and was visiting his biological sister in Lusaka, who took him to the hospital. When I visited him in the hospital, he showed all the signs of severe pulmonary disease, but he recovered and went back to the village. I was told by one of his relatives that he was put on ART, but he never openly spoke of his condition, and he left his wives to speculate about the reason for his illness. When Carlos’s health deteriorated again a few months later, the second born sister, who lived in the same village, took him to the nearby rural health centre. She had also taken his wife to the clinic, as because of his poor health, Carlos was not able to support his wives and children anymore.

Carlos had to be transported by car to the clinic as he was unable to walk. However he refused treatment, and although his sister was upset about his lack of cooperation, he insisted on getting medication in Lusaka. When I came to see him in the village, several relatives were there to look after him. He was lying on a mattress in front of his house, very weak and barely able to speak. I was there with a research assistant who had been his friend for several years. We were told that the family, represented by the sister, would not take him to any clinic any more as they considered it unhelpful. We offered transport to the district hospital, but the sister refused, saying that the family had decided that Carlos would now receive traditional medicine. It is unlikely that they were unaware of the consequences of this decision. Certainly, Carlos’s refusal to take the medicine that he had been given in the nearby health facility contributed to his sister’s reluctance to seek treatment again with the formal health-care system.

However, there was another reason, brought up by a friend and colleague of Carlos’s. According to him, Carlos had been a troublemaker in the view of many family members, and there had been a lot of competition and jealousy among Carlos’s siblings and cousins because he had so obviously been favoured by his wealthy uncle. In addition, there had been a recent dispute: Carlos had borrowed both a plough and money from his cousins, but he had not returned them. “The family is fed up with his behaviour,” Carlos’s friend said, implying that several family members were no longer willing to “lose money on Carlos”. Carlos’s sister, who had initially helped him and had been on good terms with him, might have been intimidated by other family members, as she herself had bought the traditional medicine for Carlos. She continued to support Carlos’s wives with money to meet their own and their children’s everyday needs when he was bedridden, while the youngest wife washed and cleaned Carlos’ body and brought him water and food in his last days.

Carlos’ story was not a singular case where resource-related conflicts emerging through the transition to privatisation of formerly communal property led to unresolved conflicts among siblings and cousins. David’s story revealed similar problems.

David

From the time I met David in 2002 until the end of my first research period in 2006, he had been looking after several of his family members who died from AIDS in his home. David, who lived in the same village as Carlos in the Kafue Flats, grew up with his parents and with the other wives of his father and their children. When he was 13 years old, he was sent to his maternal uncle in Solwezi, North Western Province, Zambia, to secondary school. When the uncle died three years later, he moved to live with his elder brother in the town of Kabwe in Central Province. He finished school with the help of the brother and planned to join the army. His father objected, and asked him to come back to the village and start a business trading his father’s cattle.

But in the father’s marriage, only the first two wives owned cattle. Because his mother was poor, David was shunned by his stepbrother, and his mother was marginalised within the family. Yet it was David who was given the name of his father after his father died, possibly because he was the only one with a higher education. This meant that he inherited all his fathers’ responsibilities to look after whoever was born in his father’s family. If relatives were in need of something, they asked David:

Everyone from my mother’s family, my mother’s side, had all the support from me. We were eight children born from my mother. Three of them died. Traditionally here when someone is sick, we don’t have resources, we have to sell cattle, which can support you in education, … (healthcare) and food in the hospital. And also when someone dies, you have to slaughter. And it was my responsibility because my mother had nothing. And so I slaughtered cattle, meaning my number (of cattle), instead of increasing, was constant because of such events.

Despite the changing legal and economic context towards privatisation and the nuclearisation of extended families, family heads continued to be confronted with claims made by relatives in need. When a family head lived on their parents’ and forefathers’ land, as David did, relatives usually had the right to stay there, too. As a household head, David was responsible for the well-being of all family members, and he paid for the education of his younger brothers, who were living in Lusaka. Four of his siblings, a niece and both his parents died within a few years. At least two of his siblings and
the niece had died from AIDS, in the period before the introduction of ART in rural areas. David and his first wife cared for David’s siblings, the niece and his mother, until their death. David had to pay for hospital expenses and funeral costs, and bore the emotional burden of being with relatives who died in his home.

In a casual discussion, David mentioned his disappointment at being asked for help by his stepbrothers and cousins, while he in turn experienced no support; he felt his relatives had taken advantage of him. He gave several examples of how he felt he was taken for granted as the provider of the extended family. His step-ister, for example, had wanted to build a house in David’s compound, which he had inherited from the father; according to customary rules, he was only the caretaker, not the owner, so he could not refuse her request. He allocated the land and coordinated the construction. But they were not on good terms. He complained that she gave gifts to her own siblings and but ignored David’s family completely, despite that they were now immediate neighbours. The conflict was not solely about resources, but also about her lack of recognition of David’s support. She might have resented that David had been assigned the heir by her father, or perhaps she just took his hospitality for granted. Shortly after this even, a stepbrother was found guilty of adultery with David’s wife. In 2012 David, who felt betrayed by his family members whom he had supported, decided to leave the village and move to the Copperbelt, the industrialised centre of the country, to look for paid work. He has not been in touch with any family members for at least two years, and no longer provides support to any family member.

David had inherited many obligations towards the family, but apart from the land he was cultivating there was no longer any common family property, such as cattle, under his control. He had to struggle on his own, while family members expected him to step in whenever there was a need. As with Carlos, there were many conflicts and jealousy among siblings around available resources, although these did not affect David’s willingness to help. Haller (2013) has shown how the process of privatisation of former common property led to the deep restructuring of social relations and social support networks, with obligations and resources distributed unequally. Yet, both Carlos’s and David’s cases show how legal changes in property and family law inflict stress on sibling relationships. In the absence of personal bonds to biological siblings, due to common child fostering practices, solidarity and the perceived obligation for mutual support weaken even more. Shared parenthood still imposed obligations for support, but many experiences were negative between siblings.

Teresa

Not all sibling relationships in the rural area were problematic. Teresa was cared for by her brother until her death in 2011; she had been on ART for two years but died after having experienced severe side effects that were initially not recognised. I met Teresa in 2002, when she was 28 years old and looking for a job. Originally from the Kafue Flats, she was the second born of three children born in Eastern Province, where her father was a soldier; her oldest brother passed away when she was still a child. They grew up in a Christian nuclear family setting. She and her younger brother went to school in the Eastern Province, until she was about thirteen years old. Her father retired, and her mother was no longer alive; they returned to her father’s birthplace in the Kafue Flats, where he could claim customary land because of his origin. Teresa continued school there. Soon after she had finished grade 12, 20 years old, she became pregnant. She wanted to marry the father of the child, but just at that time his brother died. He left a wife and children, so following the local practice, the widow was offered to be re-married to the brother of the deceased, that is, Teresa’s boyfriend. The widow and Teresa’s boyfriend agreed to marry to provide a home for the children of the deceased brother, and although polygyny was common, resources were insufficient for him to marry Teresa as well. Teresa nonetheless continued the relationship, and conceived three years later. During this time, she stayed with her father and her younger brother, as she had no intention of marrying someone other than the father of her sons. When she was 26, however, her father passed away. When this happened, there were rumours that witchcraft was involved, and some family members were arrested when they wanted to take the diviner to the local court. Teresa’s brother, barely 20 years old at the time, was imprisoned. Teresa was on her own for those months he was in prison, but regularly visited him to take him food, and decided to remain at their father’s place to ensure that she and her brother did not lose their land to other relatives:

That place would have been taken by other relatives of my father. So it would be difficult to bring it back. So therefore I fought hard not to leave the place, let me just stay until when my brother is grown and married.

Teresa stayed on her father’s land with the younger brother even after he married. Later, she married as the third wife of a wealthy cattle farmer, but she insisted in the unusual arrangement to remain at her brother’s homestead rather than move to stay with her husband, so she could continue to support her brother and her
Like Teresa, Thomas’s case shows that parental divorce, which is common, can reinforce ties between siblings of the same mother, as observed in Western Africa (Roth, 2014), with implications for the care that is provided in the case of sickness. Thomas was born in Mbala in northern Zambia. He was the fourth child in a family of nine siblings, four brothers and five sisters. His father was a tailor with an own enterprise. When Thomas was six years old, the family re-located to Kafue, a small town bordering the Western side of the Kafue Flats south of Lusaka. There he went to school to grade 6. When his father married another woman and moved to Luanshya in the Copperbelt, Thomas’s mother and the children were left behind. But the mother had no steady income, and Thomas wanted to continue school. Together with his oldest brother, he joined his father in Luanshiya. However, the father failed to support them; sometimes Thomas went to school, sometimes there was no money to pay the fees. His older brother stopped attending school, but Thomas was supported by his teacher, who came originally from the same area as his father. Thomas managed to go to secondary school and completed grade 12. During these years, he was on very bad terms with the stepmother. When Thomas completed school, he planned to return to his mother, who was still struggling to keep his younger siblings in school.

When Thomas returned to Kafue, he got a job in an industry as an accounts clerk and managed to rise to the position of senior accounts assistant within a few years. During this time, he supported his mother and siblings. His younger sister had married a fisherman when she was very young, but divorced after a short time and had several children to support. After she lost two of her three children to AIDS, the family realised that she had this disease, too. In the early 1990s, being HIV positive was a death sentence. When she fell sick, she was abandoned by her partner, the father of one of her children. Thomas kept his sister in his own house for a year as her health deteriorated, and she died. Thomas spoke of her poverty, which exposed her to HIV infection through engaging in sexual transactions in the fisheries (Merten & Haller, 2007):

Sometimes we ate once [a day], sometimes nothing. You know it was very tough. This is the reason why I could not blame my young sister who eventually got married to a fisherman … because she was trying to find ways of surviving … I saw a lot of friends falling sick especially in the “80s in Kafue; there were a lot of sexually transmitted diseases because of the fish trade (often implying sexual transactions between female fish-traders and fishermen) in Kafue. Even when I look at my mother she has been in the fish trade for a long time, and always tells me all of her friends (female fish traders) she use to do business with they are dying at home (as a consequence of the sexual transactions).

He did not blame his sister for having engaged in sexual relations with fishermen, even though there was a general perception in the community that the often “temporal marriages” with fishermen were nothing but a form of prostitution (Merten & Haller, 2007). I have reported elsewhere on sexual transactions in the fisheries of the Kafue flats and how they were embedded in local livelihood strategies (Bene & Merten, 2008; Merten & Haller, 2007). But despite the prevailing stigma of HIV in this context, Thomas looked after his sister and later raised her daughter until she completed her education at tertiary level.

Although Thomas supported his sister, his willingness to care was challenged by the stigma of AIDS, after Thomas returned to his mother when his brother suffered from AIDS. Thomas had not always been willing to help:

Sometimes I also felt embarrassed. … When he said ‘escort me to the clinic’ we had to hold him by the hand to make (help) him walk. I felt embarrassed; it was like people thought ‘his brother has AIDS’; it made me feel like you have committed a sin. Sometimes I used to say no, I would give an excuse. Just to avoid of being seen with him.

Nonetheless Thomas and his mother cared for the brother until he passed away; it was the mother who
used to wash and clean him. Later on, when his sister fell sick, Thomas cared for her himself. However, when she was very sick she went to stay with her mother, and it was she who cared for the sister during her last days. Other respondents also spoke of the ambiguity around caring for people with AIDS. One young woman who lived with HIV recalled that when her health was bad and she visited her brother in Lusaka, he used to say to others: “My sister who is suffering from AIDS has come, anytime now she will die and we will be burying her.” Yet, like Thomas, he continued to call to ask about her health, and when she recovered under ART, he was relieved and their relationship improved.

Discussion

Relatives, especially siblings, play an important role in therapy management and care for HIV-infected persons. Before ART was introduced in rural Zambia in 2005, being HIV positive was a death sentence, often leading to limited investments in the care of dying relatives when resources were constrained (Bond et al., 2003). As Niehaus (2007) has described for South Africa, suffering from AIDS symptoms was perceived as a stage of being “already dead”, without hope for recovery; efforts were perceived as being in vain, leading sometimes to abandonment or the cessation of care of the sick person by family members (Bond et al., 2003). The shift from the temporally limited care of terminally sick AIDS patients who were expected to die any time, to the continuous support of persons living with HIV, after the introduction of ART, appears however to be gradual, as many persons were still dying from AIDS. The availability of ART does not automatically imply that relatives are now more willing to invest in the care of HIV-affected relatives. Depending on the clinical condition of the patient, the threat of death was still a cause of stigmatisation and abandonment as soon as a person with HIV was very sick, and being left to die was a huge concern of HIV-affected persons. Even after the introduction of ART, there were still situations where death seemed unavoidable and care withheld. In Carlos’s case, personal histories and conflicts led to limited care and investments in a person, as efforts were perceived to be “in vain”, even if therapy was available. Economic constraints did not appear to have been the main problem in this case, although they may have contributed to this. Bond described the burden on the family of being HIV positive, when people knew that death was maybe only a short time ahead, where work will be impossible, when end of life care and funeral costs would have to be taken care of by the family, and when someone has to care for the surviving children (Bond, 2010; Bond et al., 2003). Many families are affected by more than one death, as reflected in David’s and Thomas’s cases, as they took on the roles of caring for surviving relatives in the 1980s and 1990s, when the many HIV-related deaths challenged kinship-based support. In addition to the direct cost for care of a sick relative, care-related work must also be valorised. Usually care work is skewed towards women in the household, limiting their time to pursue other income-generating activities (Akintola, 2006), which negatively affects the overall household income and women’s financial autonomy.

An additional dimension is the emotional relationships among family members and kin. Stigmatising reactions and the provision of care by family members may vary where relationships with HIV-positive family members are characterised by ambiguity. The past plays an important role, in terms of how HIV was acquired and how this is morally interpreted, in terms of experiences of reciprocity of support, and in terms of affection. Roth (2014), who worked in Burkina Faso, noted the persistence of a particular rights setting based on kinship structures, shaping expectations of relationships, but also described how sibling relationships were defined through interpersonal experiences shaped by emotions of love and affection, of responsibility, and of control, competition and exploitation (Roth, 2014). In a positive sense, kin relationships are defined by underlying “special” connections and felt obligations between men and women, parents and children, and significant others, characterised by the “mutuality of being” (Sahlins, 2013). But in the absence of affection, kinship obligations may no longer be considered binding, and the institution of reciprocal support between kin may weaken. In contemporary Zambia, labour migration, urbanisation and Westernisation have altered the importance and definition of kinship structures (Price & Thomas, 1999). The above case reports illustrate that it is not the transformation of kinship structures towards a more nuclear organisation of families, which decreases support between extended kin, but rather the arbitrariness of obligations following institutional change and the lack of control and sanctioning if obligations are not met that lead to conflicting situations within extended families. Historically, children were closely linked into a web of economic exchange and workforce across and between generations. Boys herded cattle, girls worked in the fields and in the house. Girls who married brought bridewealth to the relatives. Boys depended on fathers, uncles and brothers eventually, for the payment of the bridewealth. While support continues to be claimed from a family head, resources are no longer centralised under his or her control (Haller, 2013). Extended families still provide the
ties create a strong enough obligation to care for one another. Participation is strongly based on the assumption that family members may later make similar claims. While extended family relations have been increasingly commoditised, leading to a shrinking social support network, people rely more strongly on their immediate family members, such as the siblings with whom they grew up.

In Zambia, community-based and home-based care programmes are integrated into national health-care strategies, requiring on-going participation of family members and volunteers in the provision of care in the future (Aantjes, Quinlan, & Bunders, 2014). This concept of participation is strongly based on the assumption that family ties create a strong enough obligation to care for one’s relatives. Our findings have shown that this is not necessarily the case, but it depends strongly on the history of a family. Material support through social protection mechanisms may alleviate the burden of families who are expected to care for their sick members. It does not guarantee, however, that the care responds to the needs of the sick person or that affection goes along with care.

**Conclusion**

The ability to mobilise economic resources for support, a sense of common ownership of resources and identity, and a joint history of support and affection between siblings are basic conditions for the provision of care for relatives living with HIV. However, there is a risk that support claims concentrate on affluent community members, whose willingness to help may be limited by their ability to do so. Social protection mechanisms that mitigate the financial burden of sickness are a way to support family-based care. However, complex kinship relations may not always lead to the strong obligations that prescribe how care is provided, by whom, to sick relatives. It remains important to analyse kinship relations in the context of the history of the family and ideology, and to consider the meaning that is assigned to relations in view of wider economic and political processes, to better understand when relatives care and when not. These kinship relations are decisive for the effectiveness of community home-based care programmes.

**Note**

1. Sahlins (1972) distinguished three forms of reciprocity: a generalised reciprocity, where a direct return is not expected in the same form – and not immediately. Reciprocity may be balanced when investments are made only if a return is guaranteed, or it may be negative if goods can be taken away with impunity from someone, for example based on a kinship-based hierarchy allowing older siblings to take the belongings of the younger ones, as it had been common in the research area (Smith & Dale, 1920).

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