Experiences of family carers of older people in marginalised communities in Namibia

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Namibia’s lengthy colonial history and current high levels of inequality foreshadow care in the context of poverty and marginalisation, and within families that are diverse and whose care capacities are poorly understood. Focus group interviews with family carers of older people in two marginalised communities provide insights into their experiences of care. We highlight three findings: first, contexts of care perpetuate and entrench marginalisation; second, care is not widely shared within families, raising questions of what it means to ‘do family’; and, third, care has negative consequences for carers and their families, foreshadowing generational replication of carer exclusion.

Key words family carers • older people • marginalised communities • Namibia

Introduction

For more than two decades, family care has been a topic of research and policy interest. The interest has been fuelled by population ageing and by rising numbers of people with chronic health problems (Stoltz et al, 2004). It is as a result of the intersections of these processes that Katz and Lowenstein (2019: 4) have argued that ‘care and the challenges of meeting care needs have become high-priority issues for governments, employers, policymakers, practitioners and academics globally’. The United Nations Decade of Healthy Ageing (2021–30) (WHO, 2020) underscores the priority of meeting care needs. One of its four action items is that countries should have systems of long-term care for older adults who need such support. Reliance on families to provide that care is viewed as unsustainable and inequitable (Keating, 2022).

African scholars have argued that regional capacity to care for older persons is among the key issues arising from population ageing (Hoffman, 2016). A prevalent
discourse in sub-Saharan Africa is that people with long-term health problems or disabilities are well supported by their families (Thrush and Hyder, 2014). Scholars have challenged this view, arguing that regional contexts and increased care needs have resulted in a ‘care deficit’ (Schatz and Seeley, 2015: 1185), in which the ability of family members to engage in care and the quality of their care work are inadequate (Hoffman, 2016). Colonial histories, including apartheid, are important themes in these regional contexts because of their legacies of exclusion (Biraimah, 2016).

The purpose of this study is to contribute to our understanding of family care in sub-Saharan Africa. The study is based in Namibia, one of 46 countries in the region that has its particular historic, colonial and family contexts. We focus on family carers to gain insights into their care experiences. We chose carers in marginalised communities to acknowledge the Agenda for Sustainable Development goals and its mission to reduce the vulnerabilities and inequalities that leave people behind (United Nations Sustainable Development Goals, 2015).

**Contexts of family care in Namibia**

We begin by responding to the challenge presented by De Lange (2018) that to understand care, one must place it within the contexts in which it occurs. We provide information on macro (historic and colonial) and family contexts in Namibia as a backdrop for understanding the experiences of family carers.

**Macro contexts**

Namibia is a vast country covering 824,116 km². With a population of just over 2.6 million people, it has the second-lowest population density in the world, with only three people per square kilometre (Worldometer, 2021). The median age of people in the country is 22 years (Worldometer, 2021). A total of 7 per cent of the population is age 60 and older (Indongo and Sakaria, 2016). The country comprises 11 ethnic groups.

From the beginning of the 20th century, Namibia’s history has been one of marginalisation and exclusion. Between 1904 and 1907, historians estimate that approximately 80,000 indigenous Herero and Nama people died from forced labour, internment in concentration camps, malnutrition, sexual violence and genocide in what was then called ‘German Southwest Africa’. The purpose was to allow colonists to gain access to the land and its rich resources (Melber, 2017; United States Holocaust Memorial Museum, no date). Today, these rich mineral resources contribute to Namibia’s classification as an upper-middle-income country (World Bank, 2022). Mining is a source of employment for some, though wages are low and there are high levels of income inequality. Almost half the population is estimated to be living in extreme poverty (Teweldemedhin, 2015).

A parallel history of ethnic exclusion is a second theme. At the end of the First World War, South Africa was given a mandate under the League of Nations to manage Namibia. South Africa’s apartheid laws were extended, preventing black Namibians from having political rights and restricting their social and economic freedom (Hutchinson, 2021).

This century-long colonial period leading to Namibia’s independence in 1990 has resulted in successive cohorts being marginalised because of race, education and precarious employment (Indongo and Sakaria, 2016). There is evidence of the deep exclusion of older people after a lifetime of poverty and deprivation (Nangombe...
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and Ackermann, 2013). Paradoxically, these contexts of exclusion mean that family care is a key source of social security and support in older age, but family carers may be in a poor position to provide that care (Hanrahan, 2018; Agyeman et al, 2019).

Family contexts

In their introduction to an article on extended families in Namibia, Leonard et al (2022) state that the Namibian Constitution includes a principle to protect the family (our emphasis). The authors challenge the notion of a singular family, noting that in Namibia, family membership and living arrangements are diverse and fluid.

Research on families in Namibia addresses two broad themes that help us understand the family contexts in which care occurs: first, that customary practices create diffuse boundaries around family membership; and, second, that household composition and location are fluid, reflecting the country’s history of economic marginalisation. Family boundaries are diffuse, in part, through the traditional practice of child fostering. Namibia has the highest rates of child fostering in Africa, with up to 40 per cent of children not living with their biological parents (Brown et al, 2020). Fostering is negotiated by elders and is viewed as a culturally appropriate form of family life, in which resources and childcare responsibilities are shared (Brown, 2013; Leonard et al, 2022). While the cultural script of fostering is that all children in a house are treated equally (Brown, 2013), there are gaps in knowledge of the extent to which such distributed care for children fosters a setting of care for older adults.

Patterns of partnership and marriage also make family membership unclear. Marriage rates have declined substantially in Namibia, accompanied by increasing long and ambiguous processes of negotiating conjugal relationships (Pauli, 2019). As Bank and Hart (2019: 417) state: ‘until you are married, you remain part of the larger family and are socially obliged to work towards its well-being’. There are also knowledge gaps here as to how these patterns relate to the ways in which older adults and their care needs are family concerns.

The colonial legacy of ‘extraordinarily fragile livelihoods’ (Bolt and Rajak, 2016: 798) has had an impact on families through its disruption to households. Labour force insecurity and high rates of unemployment have led to youth migration to the cities to find work and to long absences for those who work in the mines. Pauli (2007) attributes the high rates of female-headed households in northern Namibia (approximately 60 per cent) to the sustained impact of the colonial contract labour system. Family households themselves may also be fragile. Evidence from South Africa shows a pattern of farm workers and their families becoming homeless when a worker is dismissed (Bank and Hart, 2019). Articulating family diversities in particular settings is important in framing understandings of such issues as how families differ in their capacities to support one another and who is likely to become a carer (Hilbrecht et al, 2022).

Literature review

Research evidence that provides background on the state of knowledge of the experiences of family carers is presented in three themes: family obligations and resources; care tasks and challenges; and the consequences of care.
Family obligations and resources

A predominant discourse in southern Africa is of strong, interdependent families who provide support and care (Hanrahan, 2018). Such familist beliefs (Flores et al, 2009) are widely held, though perspectives differ on their efficacy. Some scholars argue that care is provided ‘voluntarily, without question or remuneration, since such care is deemed to be a cultural responsibility’ (Adonteng-Kissi et al, 2020: 2). Others state that such beliefs have created a crisis in family care that leaves families with few options (van der Geest, 2016; Hanrahan, 2018; Adams et al, 2021). There has been a call for serious reflections on the question of what constitutes a fair distribution of responsibility for care (De Lange, 2018).

Evidence to date suggests that families do indeed feel a sense of obligation to care for older family members, though the reasons vary. Research from Ghana shows a strong sense of filial duty to provide care, with care provision typically assigned to female residents of large-compound households (Agyeman et al, 2019). Obligation is reinforced by the law of karma, where treating ones’ parents well is important because ‘whatever you sow you will reap’ when you later require care (Faronbi et al, 2019: 12). A similar sense of long-term reciprocity is evident in a study of women in Ghana who saw the care they provided to their own children as a justification for their expectation of receiving familial care in later life (Hanrahan, 2018).

A frequently expressed reason for care provision is that there are no alternatives. Researchers speak of caregiving as a necessity, not a choice (Agyeman et al, 2019), but as undertaken because of fear of rebuke or condemnation if they are seen as abandoning an older person (Faronbi et al, 2019). Others find that in low-resource countries, such as Nigeria, the lack of care services make family caregiving a necessity (Oyegbile and Brysiewicz, 2017). Obligations of family members to provide care may not result in adequate support to older persons. Researchers in Kenya have argued that quality of life among older persons suffers because of the lack of formal systems of care for older people (Six et al, 2019).

Care tasks and challenges

A small number of studies of the provision of family care in sub-Saharan Africa indicate that carers may spend substantial hours per day caring for their relative. Family care work can be broadly based and demanding, requiring assistance with all of the person’s daily care needs (Faronbi et al, 2019), including being available to provide long-term home-based support (Verity et al, 2021). Oyegbile and Brysiewicz (2017: 2625) define carers as ‘unpaid volunteers, usually close family members, who attend to the physical, emotional, spiritual, financial and any other needs of a loved one with a chronic, disabling illness in the home’.

Nzima and Maharaj (2020) argue that policymakers across Africa believe that care for older persons is a family responsibility, though there is limited understanding of the nature of those responsibilities. This may be in part because care takes a ‘bricolage approach, contingent or dependent on the availability of people and resources’ (Adonteng-Kissi et al, 2020: 10). In resource-poor settings, the result may be that carers struggle to manage core care tasks, such as bathing, feeding and personal hygiene, required to meet the basic needs of the person they are caring for (Verity et al, 2021). A recurring example is the difficulty carers experience in gaining access to health services and medications. Medications are often in short supply, and transport to health clinics is difficult (Oyegbile and Brysiewicz, 2017). In a study...
based in Uganda of persons with mental illness, Verity et al (2021) found that carers often experienced stigma against the person they were caring for and were refused transport or charged high fares.

**Consequences of family care**

Studies from across the region show that carers experience personal, economic, physical and social consequences, which, in turn, may negatively affect the care they provide (Faronbi et al, 2019; Kyei-Arthur et al, 2022). Carers may experience deteriorating health resulting from assuming heavy responsibilities for care over long periods of time with no access to formal services, while care-related financial expenses put families at risk of financial insecurity, requiring them to reduce expenses on their own health needs and food purchases (Adonteng-Kissi et al, 2020). Chronic illness of the older person and of carers exerts a financial drain on families (Faronbi et al, 2019).

Such consequences also affect family relationships. Despite discourses about families supporting their older members, family care often means caring alone. Carers report a sense of abandonment and isolation resulting from a lack of physical, financial or emotional support from family members (Faronbi et al, 2019). Violence is a recurring theme in some studies (Verity et al, 2021). Carers struggle to balance care with their social and economic lives (Adonteng-Kissi et al, 2020), facing difficult choices of whether to abandon or neglect their families, or to devote less time to work. Those that are self-employed lose customers and income (Faronbi et al, 2019). Evidence to date suggests that care truncates lives (Oyegbile and Brysiewicz, 2017).

In sum, Namibia’s lengthy colonial history and current high levels of inequality foreshadow care in the context of poverty and marginalisation, and within families that are diverse and whose care capacities are poorly understood. The small body of research on family care suggests that care is difficult for those who are carers, though we know little of their care experiences. In response to these knowledge gaps, we examine the perspectives of family carers to older persons in marginalised communities in Namibia about the tasks they provide, their consequences and the contexts in which care occurs.

**Methodology**

To better understand family care to older persons among marginalised people in Namibia, we draw on data from focus group discussions held with family carers in these two areas. The focus group methodology was chosen because it provides a safe setting for sharing experiences with peers, which can be especially important for people in marginalised groups (Kidd and Parshall, 2000; Scheelbeek et al, 2020).

**Research setting**

The setting for this project was the Khomas region situated in the central area of Namibia. Windhoek, the capital city, is in the Khomas region. The region has an estimated population of 342,000 (Khomas Regional Council, 2015). The main languages spoken are Oshiwambo, Afrikaans, Otjiherero and Damara/Nama. After Namibia’s independence in 1990, the Khomas region was divided into ten constituencies, each with its own local government (Namibia Statistics Agency, 2012).
Data for this study were gathered from two of these constituencies: Katutura Central and Windhoek Rural (Detering et al, 2005).

The first study site was Groot Aub in the Windhoek Rural constituency. Groot Aub is a settlement of approximately 1,400 inhabitants, located 60 km south of Windhoek. People live in shacks, with no running water, sanitation or electricity. There are no nearby banking or postal services, and there is minimal access to primary healthcare. The only shops are small and very expensive. Poor road infrastructure and a lack of public transport make access to services difficult (Iitoolwa, 2016).

The second study site was Katutura Residential Area in the Katutura Central constituency, which has a predominantly urban character. Katutura Residential Area is a settlement of approximately 24,600 inhabitants. It was established in 1959 after black residents were forcibly moved to the area under the principle of apartheid that segregated people by ethnic group (Nangombe and Ackermann, 2013). During that period, residents named the area the place where people do not want to live (Buning et al, 2016). In this community, access to resources is also very limited. Electrical power is unaffordable to most, and water is available only outside their houses. None have indoor toilets. The two communities are typical of black residential areas that are among the poorest and most marginalised communities in Namibia.

Participants and recruitment

The target population for this study was family carers of older persons residing in the Katutura Central and Windhoek Rural constituencies. Recruitment was undertaken by community leaders who were knowledgeable about members of their communities and were able to identify family carers residing in the designated areas. One of the potential challenges in this approach is that we do not know which carers were reluctant to participate because they did not wish others to know more about their circumstances or because their care duties made it difficult for them to attend. Thus, it may be that we did not learn about the experiences of carers in particularly difficult circumstances. The criteria used for recruitment were that participants were an adult child, spouse, sibling or extended family member of the care receiver, were the main carers, and were actively involved in care. A total of six focus groups were conducted with 33 family carers from the two locations.

Data collection

On the day of the meeting, the researcher screened the participants for compliance with the selection criteria before the focus group discussion commenced. Focus groups were conducted by the first author and two trained, experienced fieldworkers, who also served as translators of Oshiwambo, Damara/Nama and Otjiherero, which are the local languages. Participants were free to speak in English or any of these languages. Guiding questions included asking participants about their personal experiences of providing care, positive and negative aspects of care, and support available for older people and family carers in the wider community. No incentives were provided to the research participants, except for refreshments at the end of the focus group discussions.

All focus group discussions were held in a private setting at the house of a traditional leader, or at a community structure, such as the council office or church hall. Interviews
were audiotaped and lasted between 60 and 90 minutes. Data were collected over a two-month period during April and May 2012.

**Data analysis**

All of the audio-recorded data collected from the focus groups discussions with the carers of older persons were transcribed verbatim, and transcripts were checked for accuracy. Passages in Oshiwambo, Damara/Nama and Otjiherero were translated into English.

Data analysis was undertaken by both authors consistent with their roles on the project. The first author conceived the study and conducted the interviews as part of her doctoral research. As a resident of Namibia, she was familiar with the context and the broad issues of care in the region. She undertook the initial coding and analysis to generate a set of themes and subthemes. The second author has undertaken research on family care in several world regions, including sub-Saharan Africa, and is experienced with focus group methodology. Her role in data analysis was to assist with the identification of findings that were novel and that extend understanding of the importance of context in understanding the activities and consequences of care.

The authors met regularly to discuss preliminary themes and subthemes. As themes were developed, the first author returned to the data to extract quotes that reflected themes and subthemes. Decisions about thematic analyses were made jointly and evolved as further data extraction to illustrate themes was undertaken by the first author. The final three themes and subthemes were reached by consensus.

**Ethics**

Ethical clearance to conduct the study was obtained from the Institutional Ethical Review Committee of North West University, South Africa, and the Ministry of Health and Social Services, Namibia. Permission to carry out the study was obtained from the local councillors of the two study sites. Consent was given by each of the research participants and recorded on the consent forms.

**Findings**

Tables 1 and 2 provide a description of carers in the two study sites. Across the six focus groups, most were female, single and unemployed. Those who were working were primarily in low-wage projects, such as community gardens and brick making. Pensioners were in receipt of a small monthly pension of approximately N$1,300.00 (approximately £72). All were living in poverty. Carers ranged in age from 18 to 70 years old, reflecting generational obligations that are apparent in focus group findings. Some carers who were single had partners. They designated their relationships to the care receivers as close kin, though these are based in kinship conventions in the country. For example, a carer might refer to someone as ‘mother’ who is either a birth parent or someone who raised them, or as ‘grandmother’ because an older person took them in when their parents died or were otherwise unable to take care of them, while aunts might be long-standing close friends of the parent generation. Most carers were responsible for one care receiver, while a lesser number were responsible for two care receivers.
The overarching theme from thematic analyses of the focus group discussions is that contexts of care are profoundly difficult. The colonial legacy of marginalisation is reflected in the deprived settings in which care occurs and where care tasks are onerous and their outcomes are negative. Generational cycles of poverty and exclusion are perpetuated. For the most part, carers care alone. Discourses of large African families working together to provide care are challenged. Findings create a picture of carer contexts and exclusion that is reflected in three main themes: lack of resources impedes care; individuals, not families, provide care; and care outcomes entrench exclusion.

**Theme 1: Lack of resources impedes care**

‘The last time when I left grandmother, she suffered from diarrhoea and she was, like, doing it in the bed, and we had to clean up, every minute we had to clean up.’ (G1)

‘The clinic does not want to give us linen savers … as they say that the medical doctor did not prescribe it.’ (G9)

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‘The clinic does not want to give us linen savers … as they say that the medical doctor did not prescribe it.’ (G9)
Table 2: Sample description of family carers in Groot Aub (Windhoek Rural constituency)

<table>
<thead>
<tr>
<th>Identifier</th>
<th>Age</th>
<th>Gender</th>
<th>Marital status</th>
<th>Employment status</th>
<th>Relationship to care recipient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus Group 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G1</td>
<td>18</td>
<td>Female</td>
<td>Single</td>
<td>Student</td>
<td>Mother and grandmother</td>
</tr>
<tr>
<td>G2</td>
<td>28</td>
<td>Female</td>
<td>Single</td>
<td>Unemployed</td>
<td>Grandfather</td>
</tr>
<tr>
<td>G3</td>
<td>33</td>
<td>Female</td>
<td>Single</td>
<td>Unemployed</td>
<td>Grandmother</td>
</tr>
<tr>
<td>G4</td>
<td>36</td>
<td>Female</td>
<td>Single</td>
<td>Unemployed</td>
<td>Mother and father</td>
</tr>
<tr>
<td>G5</td>
<td>27</td>
<td>Female</td>
<td>Single</td>
<td>Unemployed</td>
<td>Grandmother and grandfather</td>
</tr>
<tr>
<td>Focus Group 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G6</td>
<td>47</td>
<td>Female</td>
<td>Divorced</td>
<td>Brick-making project</td>
<td>Mother</td>
</tr>
<tr>
<td>G7</td>
<td>39</td>
<td>Female</td>
<td>Single</td>
<td>Unemployed</td>
<td>Mother</td>
</tr>
<tr>
<td>G8</td>
<td>41</td>
<td>Female</td>
<td>Married</td>
<td>Brick-making project</td>
<td>Grandmother</td>
</tr>
<tr>
<td>G9</td>
<td>54</td>
<td>Female</td>
<td>Married</td>
<td>Small business</td>
<td>Brother and father</td>
</tr>
<tr>
<td>G10</td>
<td>50</td>
<td>Female</td>
<td>Single</td>
<td>Community garden project</td>
<td>Grandmother</td>
</tr>
<tr>
<td>Focus Group 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G11</td>
<td>40</td>
<td>Female</td>
<td>Single</td>
<td>Unemployed</td>
<td>Mother and father</td>
</tr>
<tr>
<td>G12</td>
<td>38</td>
<td>Female</td>
<td>Single</td>
<td>Retrenched (laid off)</td>
<td>Mother and aunt</td>
</tr>
<tr>
<td>G13</td>
<td>38</td>
<td>Female</td>
<td>Single</td>
<td>Childcare</td>
<td>Mother</td>
</tr>
<tr>
<td>G14</td>
<td>66</td>
<td>Female</td>
<td>Married</td>
<td>Pensioner</td>
<td>Husband</td>
</tr>
<tr>
<td>G15</td>
<td>66</td>
<td>Female</td>
<td>Single</td>
<td>Pensioner</td>
<td>Brother</td>
</tr>
</tbody>
</table>

These statements from carers provide a snapshot of the challenges carers face in providing care. From their perspective, household, neighbourhood and community contexts are unsupportive. Carers are hampered by a lack of household amenities and the inadequacies of local access to food and personal hygiene products. Carers experience little understanding or sympathy from service providers as they attempt to utilise health services, banking and income security programmes for the older person. Their goal of supporting the health and dignity of the older person seems unattainable.

Carers describe households as lacking basic amenities that make assisting the older person with personal care, such as bathing and preparing food, arduous:

‘I will go to her to clean, make food; she won’t use the electricity because she is afraid of the electricity … she only uses the fire.’ (G3)

‘We are always telling her, “Grandma, you need to bath now”, then we have to argue about it for the whole day. She won’t even talk with us just because you were telling her to bath. She would even go, like, “We don’t have soap”, but we will tell her that there is soap.’ (G1)

Participants do not see their local communities as carer-friendly. Products like food and adult incontinence supplies are unaffordable. If carers need to buy food on credit, they are confronted with shop owners who inflate the prices. Carers are frustrated by the futility of trying to meet the needs of the older person:
‘My grandmother likes fruits and vegetables more, but because I am unemployed, there is from day to day no food that she likes.’ (K14)

‘But if the shop owner decided to add a 50 cent to every item that was bought on credit … no matter if it is a pensioner … he will do it. If the sugar costs 15 Namibian dollars, the shop owner will add a 50 cent or one Namibian dollar because it was bought on credit.’ (G12)

‘Adult nappies are more expensive than baby nappies. You pay 500 Namibian dollars for two packs of nappies. And if the older person has diarrhoea, you do not want to leave your older family member in one nappy for many hours, you understand. So, the entire process is very, very expensive. Especially for someone like me who is not working; it is very, very difficult.’ (K16)

‘If someone come visit at the house, and ask, “What smells?”, I do not feel alright because the person ought to know that an elderly person is in the house.’ (K14)

Carers described poor access to health services and difficulty navigating financial services, such as banking and pensions. They saw service providers as doing little to help:

‘When my grandfather is ill, it is also very difficult … because they [clinic] does not want to borrow us the wheelchair [for transporting the patient to the clinic] … because the wheelchair will apparently be damaged by the rocks on the gravel roads. So, we have to borrow a wheelbarrow or rent a car to take grandfather to the clinic.’ (G9)

‘Transport is a problem; people do not want to carry a frail older person to put them in their cars…. Taxis refuse to transport bedridden older people.’ (K13)

‘With me, it is very difficult. The woman who knew my grandmother’s pin code [for the bank account] have passed away, and she never gave anyone the pin code. And today, I went to the bank and they told me to take my grandmother to the main branch, but my grandmother is bedridden. How do I take grandmother to the bank? We also do not have a wheelchair to push my grandmother. And there is nothing at home … my grandmother is the main breadwinner. So, the bank said, no, it is not his problem. I further asked if they cannot send a bank official to my grandmother to help her at the house, but they [bank official] replied, “No, it is not possible.”’ (K17)

‘I have a similar issue … these new registrations [for pension payments]…. It never reached my mom. You must take the older person to the pension office … and if an elderly [person] does not have the new paycard, he/she will not receive the pension.’ (K16)
Theme 2: Individuals, not families, provide care

‘I did not even realise that I have become a caregiver … how could my late sister-in-law leave my brother to me?’ (G15)

For the most part, carers are alone. The preceding wistful statement indicates surprise and bewilderment at the immense obligation that is care. Carers recount receiving little assistance from other family members who had disappeared, or were disinterested, or had withdrawn in the face of care-receiver preferences. Where family assistance is provided, it is intermittent and situation specific. Family carers do not believe that they are embedded in families that care:

‘He [older person] lived with his wife and kids, but they just all disappeared.’ (K11)

‘I’m also taking care of my grandmother myself…. My mom and others are there, but they don’t bother.’ (G8)

‘It’s not all of them [siblings] that does help; it’s only a couple of them that you can count on, but all the others are not helping.’ (K1)

‘While my mom is lying like that, she is asking me what have happened to her [other] children [others affirm]. Then, we must try to call that sibling.’ (K16)

‘In time like that [conflict], we just call my older brother. My mom loves him a lot…. He will rush to the house and will speak with my mom.’ (K15)

Carers describe family members as sometimes withdrawing or being unwilling to assist because of the preferences of the older person. Older people’s criticism of other family members or their wish to receive help from a specific family member are reasons or perhaps excuses for others to withdraw:

‘Grandma herself does not want to stay with other family members. She only wants to stay with me and the family does not care.’ (G8)

‘If someone else should bring the water, then the water is too cold…. If I do not prepare the food, then the food is not nice. All the people have withdrawn now. I am the only one left.’ (K14)

‘He does not want to be helped by other people … I must be the only one who cares for him.’ (G9)

Carers placed their own care responsibilities against this backdrop of the effective absence of a family network to share care responsibilities. Ironically, while other family members were effectively absent, family connections and obligations were the reasons that those who were carers took on this role. They spoke of long-term reciprocity across family generations, of modelling good care as insurance against their own future needs and about the stark realities of a lack of choice.
Giving back to those who have cared for you was a common reason for care. For some, there was a sense of wrapping up care relationships that reflects a sense of long-term reciprocity:

‘It’s like you need to do this and you need to finish up.’ (G1)

‘How can you throw such a person away, after everything?… Look what you have is coming from them. I have a mom and a dad, but what I got from my grandmother I never got from my mom and dad. Yes, I can give up everything.’ (K15)

‘They also looked after us when we were kids. Really, if you look at yourself, if you sit here and look, then you just think, “How did they care for me?” Then I must return the same.’ (K14)

Carers who are parents described modelling to their children what they hope will be done for them in the future. They socialise children to value caregiving across generations and to learn how to care:

‘You actually teach the children in the house also … they see from your example and will take care of you in the future. But if you are not taking proper care of the elderly, what do you expect from your children one day?’ (K12)

‘From a very young age … years ago, my grandmother has lost her leg, and I helped my mom [to take care of her]. My dad is now 81 years old, he broke his leg and developed bedsores, and I myself took care of him.’ (K15)

Care is also provided because there is little choice. Obligation comes from family connections that bind people together and because the costs of not caring are too great:

‘I did not actually grow up with my father … but I had to look after him. I became rebellious [because] he did not raise me. But then I told myself that “It is because of this man that I am here today.”’ (K12)

‘In my case, I really want to work, but then I’m thinking, “What will happen to my grandmother?”’ (G3)

**Theme 3: Carer outcomes are poor**

‘You do not relax, and eventually, you are stressed, very stressed.’ (K14)

This quote reflects the constant vigilance that care requires. With no help from others, care takes place in isolation and with no respite. There was a general feeling of being overwhelmed. Many gave up employment because they could not otherwise manage care. Lack of alternatives meant that older persons were sometimes left with children...
too young to provide care. Opportunities for carers to move out of poverty or to provide for their children were severely limited. Carers expressed feelings of being trapped and resentful. They longed for opportunities to take breaks or to be with others. Some took time away but checked in with the older person. For the most part, carers saw no way out:

‘And if I’m just at home all day long, then I feel trapped [everybody laughs in agreement].’ (K14)

‘So, I do everything alone….I only relax for 10–15 minutes watching soccer. I really don’t know any more what I must do.’ (G12)

‘When they [older persons] are asleep at night, I may go out for the night … and I must just make sure to see them early in the morning to check if they have slept well.’ (G5)

‘You seeing your friend is employed or something, playing … but while you are not doing the same….And sometimes, you become stressed and you become very angry.’ (K6)

Giving up employment to provide care and to be present was common. There was widespread disapproval of older persons being left with young children who could not provide care:

‘I take care of my mom and dad. I stopped working to look after them.’ (G4)

‘I could see that my mom cannot anymore. I was supposed to travel back to work but have decided to cancel it. I can always get money, but I must help these souls. That was how I resigned from my job as my elderly parents became weaker.’ (K12)

‘Older people stay alone or with their small children … and they cannot help.’ (G14)

‘We found this older woman very hungry … and I went into the shop and bought her milk and bread … and I told her to go home because people might be looking for her … and she replied … that her daughter went to work, her granddaughter was supposed to warm and serve her food, but the grandchild has covered her head with the blanket asleep.’ (K12)

‘In some houses, older people are just left….Even if the elderly cannot stand up, he/she is left with the children. Then there are no people in the house. Then one wonders whether the elderly had some water to drink….Now, if you are leaving someone the whole day? That is abuse.’ (K14)

Participants reported that their responsibilities towards the older care recipient often overshadow their ability to care for themselves and for their children. Time
poverty, income poverty and exhaustion place carers and their children at risk of marginalisation and exclusion being perpetuated:

‘Yeah, it is actually a very big challenge … you also have your own children … and you also need to plan for the future of your children … so it is a bit difficult.’ (G5)

‘I want to get up and work for myself. I want to take care of myself in a better way because what I’m doing here, I cannot look after myself properly … and I want to give my child what belongs to her rightfully. I cannot give her what she deserves because I must stay at home.’ (G13)

There are positive experiences for carers and glimpses of enjoyment. These moments are rare and are treasured when they occur:

‘At night, I always hear how my grandma is praying for me. We are arguing some days, but when she is going to bed, I can hear her praying for me.’ (K14)

‘There are days when they [older people] can be very interesting, one can even enjoy it. Sometimes, they [older person] are just chatting with you. [All speak together in agreement.] Grandma and I may also do some gossiping … we speak about everything. They [older people] give us blessings, which the others [family members] do not get.’ (K13)

**Discussion**

This article has aimed to provide a better understanding of the experiences of family care, its contexts and its consequences among carers in marginalised communities in Namibia. We highlight three findings: first, that contexts of care perpetuate and entrench marginalisation; second, that care is not widely shared within families, challenging discourses of the virtues of familism and raising questions as to what it means to ‘do family’ in these settings; and, third, that care has negative consequences for carers and their families, foreshadowing the generational replication of carer exclusion.

Our findings suggest that the historical legacy of colonialism and apartheid, which led to the geographic and economic exclusion of the majority of black Namibian communities, constrains the lives of carers and truncates their ability to care. We see evidence of carers, already in precarious work, further embedded in a cycle of poverty as they abandon hope of employment and miss out on opportunities to provide for themselves and their dependants and care recipients. Similar to other findings from the region, households are ill-equipped for care provision, making care work difficult and time-consuming (Nortey et al, 2017).

Carers’ narratives were that community resources, where they existed, were unresponsive to the needs of carers or care receivers. Service providers across areas as diverse as health clinics, banks, food markets and taxis displayed unsympathetic attitudes when approached. The consistency of these reactions suggests the presence of structural ageism: discrimination directed against older persons by the policies of institutions and the actions of people affiliated with them (Levy, 2022).
The finding that care is mostly provided by one family member raises questions about what it means to ‘do family’. These results suggest that discourses about the availability of large African families to provide care and their commitment to do so have been oversimplified. We know relatively little, for example, about the extent to which individuals in families are ambivalent about norms of family care or about their personal responsibility for translating these into care behaviour (for a related critique of the relationship between religious norms and family behaviour, see Bulanda, 2011). Nor do we know the extent to which diversities in family membership and resources (Hilbrecht et al, 2022) might influence which members are available for care.

Finally, the high levels of financial, personal and family consequences provide evidence of the extent to which carers and their families disproportionately assume the costs of care. Narratives of inability to buy nutritious food or incontinence supplies or bed linen are reminders of the depth of poverty of these carers. In one of the few studies of the financial costs of care in the region, Nortey et al (2017) found that carers in Ghana had disproportionate levels of out-of-pocket costs, indirect costs because of lost wages and caregiver burden.

One wonders the extent to which we see an example of moral injury here (Akram, 2021), in which carers are acting in ways that are counter to deeply held moral beliefs about how they should provide good care for their older relatives in order to reciprocate. Under such difficult circumstances, risks of abuse are high (Ananias and Strydom, 2014). Paradoxically, carers socialise their children to be carers because they expect to need care in their own later life, increasing the likelihood of the generational transmission of inequality.

The United Nations Decade of Healthy Ageing (2021–30) has as its mission improving the quality of life of older people, their families and their communities, and of leaving no one behind (Keating, 2022). Evidence from this study suggests that carers, the persons they care for and their own family members are among those already left behind and whose care responsibilities further exclude them.

Now is the time to set aside the ongoing reluctance in southern Africa to take public notice of what has for too long been deemed the private work of families (Nortey et al, 2017). At the national level, government commitment to action on the principles of the campaign to end ageism (World Health Organization, 2021) would do much to assist service sectors in recognising and challenging institutional ageism, especially in health and finance. Regulations around pension benefits warrant review to determine areas of vulnerability and reduced access to those most in need. In-home services to relieve family carers would also benefit young people in need of employment, a key principle of the care economy in the region (Aboderin and Beard, 2014). The government of Namibia has begun to engage with these issues by commissioning a draft national policy on older persons and related legislation on the rights to care and protection of older persons (H, Mouton, personal communication, 26 August 2022). If enacted, these tools could signal a commitment to developing systems of long-term care that take into account the needs and capacities of family carers (Dovie, 2019).

A single study cannot begin to address all of the issues relevant to family care in Namibia. We took as our point of entry the experiences of carers whose voices have not been heard. We chose a methodological approach that allowed carers to share their experiences to the extent they wished to do so in the presence of other carers and with an interviewer who is an insider. We realise that some experiences may not
have been shared and that some carers in these small communities, where people are known to each other, may have chosen not to take part. In future research, individual interviews with carers are needed to fill some of these gaps. Additionally, gaining the perspectives of older adults will add knowledge of such issues as the extent to which they view their current receipt of care as part of a lifetime of shared responsibility up and down the generations.

This study has revealed the need to create a much more detailed understanding of the place of families in family care. Sweeping statements, such as that African families care for their older members, that families are in decline and are unable to care, or that families should not be held responsible for care, must be set in context. We see three research priorities that would begin to fill these gaps. The first priority is to document family diversity by mapping relationships, household composition and the ways of doing family in settings where family care is being provided. The second priority is to determine the pathways into care of current family carers in order to begin to understand whether families provide care or whether they ‘choose’ a family member to undertake care work. The third priority is to elicit the perspectives of older adults with care needs and family carers about who provides care, who is unavailable and where they would place care responsibility within their families.

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Conflict of interest
The authors declare that there is no conflict of interest.

References


Experiences of family carers of older people in marginalised communities in Namibia


