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AIDS and older Zimbabweans: who will care for the carers?

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Abstract

The AIDS pandemic has wrought havoc on family structures in Zimbabwe, leaving numerous children orphaned in its wake. Older people, grandparents in particular, play a critical role in looking after these children. However, what is not appreciated is the critical question of who will look after the old people in their time of need.

Recent estimates indicate that in Zimbabwe more than 200 000 people have developed AIDS. The death rate has been reported as about 500 a week. It is also estimated that over 10% of Zimbabwe's adult population are infected by the HIV virus (Blair Research Institute, 1997). In Zimbabwe, as elsewhere, mortality resulting from AIDS occurs mainly in the sexually-active age groups. Peak HIV infection and AIDS occur at relatively young ages in both men and women, although a fairly large number of cases have been diagnosed in babies and younger children.

A number of explanations have been advanced to explain this phenomenon. Chief among these is the explanation that older people are no longer as sexually active as younger people and have less chance of being infected. (In African countries, heterosexual infection is the chief mode of transmission of the HIV virus.) Another reason advanced is that the AIDS virus has visited at a time when people who are at present elderly, were in late middle age – a time when people generally tend to become stable and less promiscuous. The fact that the older section of the population is small (when compared to other cohorts in the population pyramid) also explains why few older persons succumb to AIDS. Whatever the reasons, the fact is that Zimbabweans aged 60 years and over have one of the lowest rates of AIDS-related deaths in the country.

The elderly largely escape AIDS, however they suffer the consequences of the younger generation who, being at high risk, contract HIV and AIDS. The source of the elderly's suffering is two-fold: First, older individuals are frequently obliged to look after grown-up sons and daughters who are afflicted by the virus and will eventually die. The sons and daughters will expect to be nursed by their elderly parents, aunts or uncles, often with extremely limited resources.

Second, and perhaps more importantly, the elderly parents are obliged to look after the grandchildren left behind by sons and daughters who die from AIDS. UNICEF reports show that children orphaned by AIDS are possibly the largest and fastest-growing group of children in "difficult circumstances" in Zimbabwe (UNAIDS, 1997; UNICEF; 1991). The reports estimate that by the end of 1996, approximately 8% of children under 15 years of age in the country had lost their mothers through AIDS.

Many of the children are not infected themselves. Studies conducted elsewhere show that about two-thirds of children born to HIV-positive mothers do not contract the infection and grow up to be as healthy as other children in the community (UNAIDS, 1997). However, in spite of not carrying the virus, the children will nevertheless suffer untold hardships. Above all else, these children need someone to look after them.

The options

In Zimbabwe, as elsewhere in the developing world, a number of options exist for looking after children orphaned as a result of AIDS. The options have been promoted by a number of agencies, including the Zimbabwean government's Department of Social Welfare. Various voluntary welfare organizations have also played a key role in promoting the options. These agencies include the Farm Orphans Support Trust (FOST), established a few years ago for the purpose of soliciting and facilitating support for children in especially difficult circumstances, particularly orphans on commercial farms. A number of other similar institutions exist and are dotted across the country.

The strategies utilized by organizations such as FOST (Parry, 1996) and others, which operate in Zimbabwe and are involved in tackling the problem of caring for children orphaned by AIDS, include the following:

- Placing the children (i.e. orphans) in institutions.
- Placing them with families willing to provide "informal" foster care to such children.
- Older siblings (mainly child heads of households) overseeing the care of such children.
- Getting elderly women (or men) to volunteer to look after orphaned children.
- Getting grandparents to look after the children within an extended family network.

The impact of the various strategies has been variable and the majority of the strategies have some limitations. For instance, a major problem with institutions operated by AIDS Service Organizations (ASOs) has been that thusfar the organizations can only cater for a few hundred orphaned children at a time, which has been problematic given the magnitude of the problem (Shumbamhini, 1997). Despite a widespread belief that orphans in Zimbabwe are well-served by ASOs, there is a growing realization that such care is inadequate and that the

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children are in fact a neglected group. It is currently estimated that some 200 000 children have already been orphaned by AIDS in Zimbabwe, and that this figure is expected to rise to an unprecedented 600 000 by the year 2000 (Shumbamhini, 1997). This situation calls for more concerted efforts among all concerned.

In some instances, fostering and adoption have been preferred strategies for caring for orphaned children. Indeed, the remarkable generosity of many Zimbabweans in this regard has been shown by the relatively high incidence of fostering of orphans by non-relatives, often by neighbours (Mupedziswa & Kanyowa, 1997). Studies done elsewhere have shown that families which have experienced a death as a result of AIDS were more likely to take in children orphaned by the disease from other households (UNAIDS, 1997). This appears to be true in Zimbabwe as well. Meanwhile, adoption as an option in which orphaned children are placed with non-relatives has been observed to have a number of limitations. A major problem relates to cultural factors. Given that Zimbabwean culture generally dissuades families from adopting a non-relative, this option has encountered some hitches and hence needs to be approached with great sensitivity, which slows the process of assisting such children.

Placement of children orphaned by AIDS within the extended family network, which includes grandparents, aunts and uncles, appears to be the preferred option in Zimbabwe (Powell, Morreira, Rudd & Ngonyama, 1994). Thus, many orphaned children end up being looked after by their grandparents, aunts or uncles, if not by neighbours or strangers. Cases of grandparents looking after ten or more grandchildren have been documented in the literature on the impact of AIDS in Zimbabwe (Department of Social Welfare, 1995).

These elderly people struggle to look after their orphaned grandchildren. Nyanguru (1991) has observed that much of the real impact of AIDS-related mortality in this context will not fall upon the afflicted who, to put it bluntly, face death within a relatively short time. Rather, "The impact will affect none more than the surviving grandmothers (and indeed grandfathers) – who will need to provide care – rather than the bewildered but (often) unaffected remaining children" (1991: 46).

The sad fact is that these elderly people, nearly in the twilight period of their lives, would under normal circumstances be looking forward to being cared for by the same sons and daughters who are dying from AIDS – and who will leave them with grandchildren to care for. Often no meaningful resources will be left to assist them to look after the grandchildren (Powell *et al.*, 1994). In many instances, the resources would have been exhausted in efforts to alleviate the suffering of the dying individuals, so that by the time that they die, virtually nothing is left. People are known to go to such great lengths to find a cure for their affliction, that they will sell their house, cattle and other belongings to raise funds for treatment, exhausting their entire savings in the process (Jackson, 1992).

The caring roles of the elderly

The caring roles of the elderly are of two types: Those relating to care for their adult children (i.e. sons and daughters) dying from AIDS; and those relating to care for the grandchildren orphaned by AIDS.

Care for adults

The degree of sacrifice which elderly parents will be prepared to make to care for sons and daughters who are dying from AIDS will depend upon the socio-economic status of a son or a daughter. Where the son or the daughter has held a steady formal job with a pension and perhaps medical aid benefits, the burden may be slightly lighter for the elderly parent.

However, in the vast majority of cases, adults dying from AIDS are poor and may not have provided for contingencies; they may therefore end up being looked after by elderly parents who must nurse them, often with meagre resources. When these sons or daughters die, the elderly are left not only with memories of the pain and suffering experienced by the deceased but with grandchildren to look after with extremely limited resources.

Care for orphans

Children orphaned by AIDS have created a serious burden for the elderly. As with all minors, these children have several needs, the majority of which the elderly must struggle to meet. The needs are emotional, social and economic; the children require particular and undivided attention (Mupedziswa, 1997b).

Children need schooling, medication from time to time, socialization, counselling and disciplining. Above all, they need food, clothing and shelter. As elsewhere in the Third World, evidence in Zimbabwe suggests that children orphaned by AIDS may be at a greater risk of dying of preventible diseases and infections, because of the mistaken belief that when they become ill, it must be due to AIDS and therefore there is no point in seeking medical help (UNAIDS, 1997:15). Although the grandparents may themselves be destitute and hardly able to afford to support these children, they will struggle to do their best to do so. Interestingly, the majority of studies have shown that households with the greatest number of dependents were the most likely to take in additional orphans (Mupedziswa, 1997a).

The impact of the Economic Structural Adjustment Programme (ESAP)

In Zimbabwe, the debased situation of the elderly has been exacerbated by austerity measures brought about by the IMF/World Bank-prescribed economic reform measures, including ESAP (Nyanguru, 1991). These measures have resulted in the sky-rocketting of prices of basic commodities, the introduction of cost recovery measures in education and health, and the de-control of prices, among other measures. A combination of these factors, the intermittent drought episodes experienced in the country, as well as the stigma attached to an AIDS death in Zimbabwe, have wrought havoc on the struggle of the elderly to support children orphaned by AIDS.

The introduction by government of the Social Development Fund (SDF), intended to mitigate the impact of ESAP on the poor, administered through the Department of Social Welfare, has done little to alleviate the suffering of older people caring for AIDS orphans. Indeed, while individuals who earn incomes below a threshold of Z$400 (US$33) are entitled to free medical attention, in reality they are required to pay for medicines – a tall order indeed for the majority of older people. The same applies with education; theoretically, primary education is free for certain categories of the population, yet studies show that so-called free education in fact costs around Z$84 (US$7) per head per annum, since families are expected to pay for school uniforms, stationery and other essentials (Loewenson & Mupedziswa, 1996).

The elderly need caring for too

The vast majority of older Zimbabweans are poverty-stricken. Studies (e.g. Nyanguru, 1991) have shown that many older people are based in rural areas and have no steady

source of income as the vast majority are economically inactive. If employed, they have low-paying jobs. In the informal sector, their earnings are invariably quite low (Brand, Mupedziswa & Gumbo, 1995). In the formal sector, the majority are employed on mines and farms, and in domestic service where wages are extremely low. In most instances, the educational level of older people is very low, such that they cannot command a decent income – a factor which has helped to consign them to conditions of abject poverty and attendant squalor.

In the context of their poverty, older persons have many needs, which in the majority of cases they cannot meet on their own. They have a need for health care, decent food and proper shelter. Access to health services is often a problem. The food which they have often lacks protein, which may lead to malnutrition. They also need dental care.

Under normal circumstances, grown-up sons and daughters are expected to support their elderly parents, by buying them items of clothing and groceries, and providing general maintenance, including paying for health services. With an increasing number of deaths from AIDS, the number of sons and daughters in a position to support older parents is rapidly diminishing. Yet it is incontrovertible that the elderly need help from this source. The situation is likely to get worse, given the sharp increase in the number of people of economically-active age who are dying from AIDS. While close relatives are landed with the task of looking after the orphaned children, where these relatives are elderly they will in time die and the orphaned children will be left virtually on their own. The death of a caregiver grandparent, uncle or aunt may leave a serious vacuum in which there is virtually no-one else in the extended family network who is willing or able to care for the children. This situation has given rise to orphan households headed by older siblings, which has triggered off an unprecedented increase in the number of households now headed by children throughout the country.

The critical issue of who will look after these elderly people in their hour of extreme need – when they finally succumb to old age and can no longer fend for orphaned children nor themselves – has hardly been addressed.

Looking into the future

The AIDS pandemic has had a devastating effect on family structure in Zimbabwe. Older people left behind by sons and daughters who die from AIDS have had to fend not only for themselves but for their grandchildren. Clearly, a growing number are finding it difficult to cope with the trying situation. Their woes have been exacerbated by the impact of the economic reform programme and its obsession with austerity. It is obvious that older persons have already become an important cog, both in helping to nurse AIDS-afflicted and dying sons and daughters and in caring for orphaned grandchildren. They therefore need support from various sources and to be empowered to continue to discharge these important duties in a meaningful and effective way.

A way to strengthen the work of the elderly in this regard could be by making training available to them in home-care chores, to enable them to assist their dying sons and daughters with greater confidence. Above all, they need resources to enable them to assist their grandchildren orphaned by AIDS more effectively. The resources could be mobilized from various sources, including government, NGOs and churches. Government support can be both direct and indirect. Direct support could be in the form of short-term food hand-outs, materials (e.g. plastic gloves), and so on, while indirect support could take the form of free education and free health care for orphaned children. Tax credits, where appropriate, could be considered.

The large number of "players" in the field of care for children orphaned by AIDS in Zimbabwe is commendable. What seems to be of some concern is an apparent lack of co-ordination of care, with many ASOs operating on their own. What is needed therefore is for all concerned to resort to the four "C"s: consultation, collaboration, co-operation and co-ordination of effort. While the institutionalization of children orphaned by AIDS may release the elderly for other chores, it is not a long-term answer to this problem, as institutionalization is both stigmatized and costly. A more effective option might be the promotion of community-based initiatives (Shumbamhini, 1997). However, such initiatives, tend to ultimately place the challenge of looking after orphaned children squarely on the shoulders of the elderly – and hence the prudence of empowering and strengthening the capacity of the elderly in caring for these minors.

A frightening but inescapable reality is that older people are not immortal. When the time comes for them to die, they will themselves need assistance. The question of who will care for them therefore becomes exceedingly critical. The various organizations which provide care for children orphaned by AIDS invariably appear to be oblivious of this need; indeed, they appear to have overlooked this pertinent factor, if their current focus and thrust are anything to go by.

Government as well as various organizations which cater for children orphaned by AIDS should not down play the likely plight of the "orphaned elderly" who themselves will need care, having expended an enormous amount of their energy on caring for their sons and daughters who eventually die from AIDS – and perhaps more importantly the grandchildren orphaned by AIDS. Placing these elderly people in institutions may not be the long-term answer, given financial considerations in view of their fairly large number in an ESAP environment that is characterized by limited resources. In any event, many older Zimbabweans for cultural reasons may not tolerate being placed in an institution. Hence, this option may be problematic and not feasible. The matter of who should pay for their upkeep in an institution is also critical.

Conclusion

Thus, after having cared for children orphaned by AIDS, older Zimbabweans, when they die, deserve a decent burial. A decent burial is the least that Zimbabwean society can give them, if only as a way of expressing appreciation and gratitude for the work and care which they gave when they were alive. A decent burial is regarded as especially important in Zimbabwean society. Any debate on assistance for the elderly in Zimbabwe must therefore not lose sight of both the role which these people may have played in nursing AIDS-stricken sons and daughters and in supporting grandchildren orphaned as a result of AIDS. Above all lies the question of who will care for these elderly persons? What is needed are measures to strengthen the extended family network. Such measures might help to ensure that there will always be someone to care for older carers when their hour of need finally beckons.

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