THE EFFECT OF HIV/AIDS ON ELDERLY WOMEN IN THE RURAL AREAS OF ZAMBIA: A CASE STUDY OF CHONGWE RURAL

By

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DECLARATION

I **Molly Sakuringwa-Samakai** do hereby declare that this dissertation represents my own work and that it has not been submitted for a degree at the University of Zambia or at any other University and that it does not incorporate any published work or material from other thesis.

Signed ----------

Date ---------- 7th July 2006 ----------

APPROVAL

The University of Zambia approves this dissertation by *MOLLY SAKURIGWA-SAMAKAI* as fulfilling part of the requirements of the Master of Arts Degree in Gender Studies.

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ABSTRACT

HIV/AIDS has been acutely experienced in the rural areas of Zambia. In fact the effect of HIV/AIDS on elderly women has changed their role from being looked after to looking after others especially grandchildren, after their parents have died of HIV/AIDS. Therefore the epidemic has slowly but surely changed their roles as provided for to providers of medical care for their sick adult children and education for their orphaned grandchildren In Zambia at the end of 2001, more than 1.2 million people were living with HIV/AIDS out of a population of 9.8 million. The Zambia Demographic health Survey conducted in 2001-2002 confirmed that the prevalence rate in Zambia was 16% among adults of reproductive age, 17.8% for women and 12.9% for men.

The overall objective of the study was to examine the effect of HIV/AIDS on the elderly women aged 60 years and above in the rural areas of Zambia. The study sought to investigate the socio-economic, psychological, and physical effect of HIV/AIDS on the elderly women. It also aimed at finding out their coping mechanisms. The study further assessed the roles played by formal support systems such as the Government, NGOs, and the Church in providing assistance to these elderly women.

The study was undertaken between August and September 2005. The study utilized the qualitative research technique. This approach was used so that the researcher could record the spoken words of the participants. This method also enabled the researcher to observe the participants behaviour and record it accurately. The participants were also studied in their natural environment, that is, the elderly women at their homes and the key informants in their offices. This method had an advantage because the participants were able to express themselves freely to the researcher. Employing qualitative methods was useful also in providing an in-depth understanding of the situation of the elderly women in the study. Data for the study was collected via one on one unstructured, in-depth interviews with twenty five participants. These participants included twenty elderly women aged 60 years and above who were either caring for an adult child infected with HIV/AIDS or had lost an adult child because of HIV/AIDS. The study was comprised of five key informants, one Government official from the Ministry of Community Development, three representatives from three Non-Governmental Organisations, namely, World Vision, Christian Children's Fund, and Facing the Challenge of AIDS, and one church official from the Catholic Diocese.

The results of this study indicated that the legacy of the increasing number of deaths of the young adults in the productive age groups (19-49 years) in Chongwe rural is having far reaching social, economic, physical and psychological negative implications on the elderly women aged 60 years and above. Empirical evidence from the study show that 70% of the elderly women had suffered the loss of a child from HIV/AIDS, and 30% were caring for a sick adult child. The study has revealed that 75% were caring for school-going children who were orphaned by HIV/AIDS.

This research indicated that all these elderly women with income that could hardly support their daily basic needs had an extra burden of providing basic needs for their orphaned grandchildren. The study revealed that, for all the twenty elderly women the combined effect of increased care-giving responsibilities and decreased economic support due to depleted human capital and low productivity had created a new situation for them. The research also found that the major coping strategy employed by the majority of these elderly women was earning an income by working on other people's farms (planting, weeding, and harvesting). The study shows that traditional support structures such as relatives, friends, and neighbours assisted in caring for the patients, by providing food and moral support but did not assist them with school requirements and medical costs because they too were experiencing similar problems. The study further indicated that 70 % of the elderly women pointed out that the assistance that was provided on a monthly basis was inadequate and irregular. On the question about Government assistance all the 20 elderly women in the study reported that they were not beneficiaries to any Government assistance and 40% complained that they were not aware about this assistance.

In conclusion, HIV/AIDS has had a severe negative effect on elderly women in the rural areas of Zambia and this pandemic has indirectly changed the role of the aged from being provided for, to providers of care for their sick adult children and the orphaned grandchildren without even the basic necessary resources. This is now posing an additional burden on them, further increasing their vulnerability. In the study this kind of scenario was found to contribute to the psychological and physical trauma and challenges that these elderly women suffered. In view of the findings the researcher recommended that the different needs, roles and responsibilities of elderly women be acknowledged and included in programs and policies addressing this pandemic.

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Ultimately, I am grateful to the Almighty God for his love which surpasses all understanding; he surely is my Rock. The success of this research study was a result of contributions from various individuals, institutions, and organizations. My special gratitude goes to my Supervisor, Dr Fay Gadsden for her comments, advice and guidance. Her encouragement made me persistent in the overwhelming task of completing the work.

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To my dad Mr E.T Sakuringwa and my late mum Mrs Fungai Sakuringwa, they laid the foundation for my education and I wish to express my everlasting gratitude to them for teaching me all the values that I hold so dear. To my sisters and my best friend Martha Akapelwa I thank you for being there for me always in many ways. I would like to thank Regina Numwa posthumously, who served as a research assistant on my team, without her assistance this dissertation would not have been complete, her loss remains so unbearable. I also owe gratitude to the staff of the Catholic Diocese Home Based Care programme in Chongwe, Lilian Banda the UN Volunteer, CCF, FTC and World Vision for the warm welcome and co-operation that they accorded me. Last but not least, my heartfelt gratitude goes to my wonderful husband Ambassador Bob Mbunji Samakai, I have learnt genuine love through him for which I am grateful and the encouragement he gave me each time I felt like giving up. To my children I thank them for making it possible for me to have peace of mind to carry out this research with little anxiety. Finally I thank all other persons, too numerous to mention that contributed variously towards the completion of this dissertation.

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ACRONYMS

ACC	Area Coordinating Committee
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
CCF	Christian Children's Fund
CSO	Central Statistics Office
DATF	District AIDS Task Force
FAO	Food and Agriculture Organisation
FTC	Facing the Challenge against AIDS
HAI	HelpAge International
HBC	Home Based Care
HIV	Human Immune Virus
IGA	Income Generating Activity
ILO	International Labour Organisation
NAC	National AIDS Council
NGO	Non-Governmental Organisations
OVC	Orphans and Vulnerable Children
PLWHA	People Living with HIV and AIDS
UCZ	United Church of Zambia
UN	United Nations
UNAIDS	United Nations Programmes on HIV/AIDS
UNDP	United Nations Development Programme

UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIS	United Nations Information Services
USAIDS	United States AID
VCT	Voluntary Counseling and Testing
WHO	World Health organization
WV	World Vision
ZDHS	Zambia Demographic Health Survey

DEDICATION

This Dissertation is dedicated to my dear husband Bob Mbunji Samakai for being a never ending and invaluable pillar of support and encouragement. To him I am forever indebted. I also dedicate this piece of work to my brilliant and wonderful children, Nyachawona, Bobby (Junior) and last but not least Victoria.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This study examines the effect of HIV and AIDS on the elderly women aged 60 years and above in the rural areas of Zambia, a case study of Chongwe Rural.

HIV /AIDS is unique in history, in its rapid spread, its extent and the depth of its impacts. It is also a tragedy for the individual men, women and children who are directly and indirectly affected by it, and presents a threat to the livelihood of households, communities and ultimately whole countries. This pandemic is unraveling years of hard-won gains in economic and social development worldwide. HIV/AIDS is not only an increasing cause of death among adults, infants and young children, it is also impoverishing families leaving behind growing numbers of orphans in its wake.

The UNAIDS (2004) reported that since the first AIDS case was diagnosed in 1981; the world has struggled to come to grips with its extraordinary dimensions. Now, more than 20 years later, 20 million people are dead and 37.8 million people world wide are living with HIV and AIDS. The UNAIDS further reported that in 2003 an estimated 4.8 million people became newly infected with HIV worldwide. The United Nations Population Division (2003) also observed that Sub-Saharan Africa has just over 10% of the world's population, but is home to close to two thirds of all people living with HIV and AIDS, some 25 million. According to UN (2003), Southern Africa remains the worst affected region in the world, with data from selected antenatal clinics in urban areas, in 2002 showing HIV prevalence of over 25%, following a rapid increase from just 5% in 1990.

The HIV /AIDS epidemic has had a devastating but underreported impact on the elderly women, especially those left to care for sick adult children and young children orphaned

by AIDS. About 13 million children have lost one or both parents to HIV and AIDS, the vast majority in Sub-Saharan Africa (USAID, 2002). New analysis of data from UNICEF (2004), show that grandmothers' responsibility for the orphans is increasing as the epidemic progresses.

The legacy of the increasing number of deaths of men and women in their productive age groups (19-49 years) in rural areas is having far reaching economic, physical and psychological implications on the elderly women. For these women the combined effect of increased care-giving responsibilities and decreased economic support due to depleted human capital and low productivity has created a new situation for them. Moller (1997) pointed out that in Africa AIDS is called the grandmother's disease because the burden of caring for the sick and the orphans falls on these elderly women.

Since the 1980s, HIV/AIDS had rendered an enormous burden on the Zambian society nationwide. Zimmer and Dayton (2003) and Population Council (2003) on the detrimental consequences of the AIDS epidemic for older people in Sub-Saharan Africa, suggested the need to investigate their characteristics, living arrangements, and well being. They examined the living arrangements of persons aged 60 years and above in 16 countries and the tendency of the elderly women to live with children and grandchildren, as well as distributions and determinants. Results showed that older people in Sub-Saharan Africa live in a variety of household arrangements. Older men were more likely to live in a nuclear household while older women were more likely to live in extended families with either their sons or their daughters. A similar research that was conducted in Botswana by Apt (1996) and Akinsola (2000) revealed that elderly women tend to live in vertically extended families, particularly with their sons. The research also showed that the co-residence of the elderly with their adult children contributes substantially to the well being of the elderly women. According to Barnett and Whiteside (2002) the epidemic has profound implications for economies in affected regions, as primary wage earners and caregivers fall sick, require care and eventually die, usually consisting of individuals of prime working age

According to the United Nations (2001), two thirds of elderly people aged 60 years and above live in developing countries. The United Nations projections indicated that death from AIDS will change the young-old ratio in Sub-Saharan Africa from 15:1 in 2000 to 4:1 in 2050. Owen (1999) pointed out that the world of elderly people is a predominantly female world because throughout the world male life expectancy is lower than that of women.

HIV/AIDS has been acutely experienced in rural areas. A Fact Sheet prepared by the Food and Agricultural Organisation (2000) clearly describes the threat to rural Africa. It indicates that two thirds of the population of the twenty five most affected African countries live in rural areas and that information and health services are less available in rural areas, meaning that rural people are less likely to know how to protect themselves from HIV and, if they fall ill, less likely to get care. In fact the effect of HIV/AIDS on elderly women has changed their role from being looked after to looking after others especially grandchildren after their parents have died of HIV/AIDS. Therefore the epidemic has slowly but surely changed their roles as provided for to providers of medical care for their sick adult children and education for their orphaned grandchildren. Many elderly women are facing the task of providing for themselves, their sick adult children as well as their orphaned grandchildren just at the time when their incomes are decreasing (HelpAge International, 2003a).

In Zambia at the end of 2001, more than 1.2 million people were living with HIV/AIDS out of a population of 9.8 million. The Zambia Demographic and Health Survey conducted in 2001-2002 confirms that the current prevalence rate in Zambia is 16% among adults of reproductive age, 17.8% for women, and 12.9% for men. Consequently, HIV/AIDS is having a major impact on the health status of the population. The rate of population growth declined from 3.5% to about 2.6% with increases in mortality as a result of AIDS and related diseases playing a key role. The estimated HIV and AIDS prevalence in urban areas was more than 23% while in the rural areas it was about 11 % (CSO, 2003).

However, the safety net provided by grandmothers is stretched very thin. The elderly women already make up a significant proportion of the poorest, and HIV and AIDS exacerbate the extreme poverty faced by many elderly women headed households compromising the older carers ability to care adequately.

Given these realities, this study addresses the socio-economic, psychological and physical effect of HIV/AIDS on elderly women, aged 60 years and above in the rural areas of Zambia, with a specific focus on Chongwe Rural. The dissertation highlights the difficulties these elderly women are experiencing in looking after their sick adult children who are infected with HIV/AIDS and the orphaned grandchildren and makes recommendations on the strategies which will help elderly women cope with the epidemic.

1.1 Statement of the Problem

The elderly women in Zambia especially in the rural areas are a vulnerable group and the HIV and AIDS pandemic is now posing an additional burden on them, further increasing their vulnerability. During their old age, when they may require support and are expected to be looked after, the elderly women are the ones taking care of others without even the basic necessary resources. Therefore this study will be carried out with intentions of finding out how HIV and AIDS has changed the role of elderly women in the rural areas of Zambia.

1.2 Objectives of the Study

(a) The General Objectives

To examine the effect of HIV/AIDS and poverty on elderly women in rural areas, a case study of Chongwe Rural in Zambia

(b) Specific Objectives

(1) To analyze the social, economic, psychological, and physical effect of HIV and AIDS on the elderly women.

(2) To find out the elderly women's coping mechanisms.

(3) To assess the role played by the informal and formal support networks that provide assistance to the elderly women.

(4) To make recommendations on the strategies which will help the elderly women cope with the epidemic.

1.3 Research Questions

The following research questions were asked in the study:

1. What is the elderly women's perception of HIV/AIDS?

2. How do the illness and/or death of an adult child infected with HIV and AIDS affect elderly women economically?

3. How do the illness and /or death of an adult child from HIV and AIDS affect the elderly women socially?

4. How do the illness and /or death of an adult child from HIV and AIDS affect the elderly women psychologically?

5. How do the illness and /or death of an adult child from HIV and AIDS affect the elderly women physically?

6. What key constraints are they facing?

7. What are the elderly women's sources of income?

8. What type of assistance does the Government, NGOs and the Church, provide to the elderly women?

9. What strategies can be recommended to help the elderly women cope with the epidemic?

1.4 Significance of the Study.

In Zambia there seems to be some lack of information and understanding in this area of AIDS support for the elderly women especially in rural areas. Most studies on HIV/AIDS and elderly women merely give a skeletal picture of these women by simply mentioning them. Therefore the information that will be generated from this study will be a contribution to the existing knowledge on elderly women in Zambia.

1.5 Limitation of the study

The study was limited by geographic coverage because it was limited to Chongwe Rural only.

1.6 Structure of Dissertation

The dissertation is divided into five chapters. Chapter one introduces the study, the problem, the objectives, and the significance of the study. Chapter two reviews the literature related to the study. Chapter three provides the research methodology which was used for the study. Chapter four provides analysis and discussion of the findings of the study. The conclusion and recommendations are contained in chapter five.

1.7 Operational Definitions of Terms

For the purpose of this study, the following definitions are used.

Acquired Immune Deficiency Syndrome AIDS: At this stage any infections to the body are likely to cause serious illness leading to death if not reversed through medical intervention.

Ageing: Refers to the behaviour of the organisms with age, which leads to a decreased power of survival and adjustment.

Anti-Retroviral Drugs: medicine that is used by people infected with HID/AIDS to control the disease.

Empowerment: This is the process of generating and building capacities to exercise control over one's life.

Gender: This refers to socially constructed roles and responsibilities assigned to women and men in a given society. It is learnt and changeable over time.

Gender inequalities: This is when social cultural beliefs and structural arrangements favour one sex over another.

Household: as defined in Zambia consists of a group of people who eat and live together.

Human Capital: refers to the value of human skills and other acquired abilities needed to create wealth.

Human Immunodeficiency Virus (HIV): is the virus that causes Acquired Immune Deficiency Syndrome (AIDS). It destroys capacity of the body to fight infections.

Patriarchy: A society, system or organization in which men have all or most of the power and influence.

CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

This chapter presents a review of the literature related to the study. Section 2.1 will discuss literature on the role of elderly women as carers of sick adults and children orphaned by HIV and AIDS firstly at global level, in Africa and finally in Zambia. Section 2.2 will present literature on the socio-economic effects of HIV and AIDS on elderly women. Section 2.3 will look at literature that discusses the psychological and physical effect of HIV and AIDS on elderly women. Finally section 2.4 will discuss literature on the networks for survival for the elderly women.

2.1 The Role of Elderly Women as Carers of Sick Adult Children and Grand children Orphaned by HIV and AIDS

This section reviews literature on studies that have been conducted on the role of elderly women as carers of sick adult children and grandchildren that have been orphaned by HIV/AIDS.

2.1.1 Global Level

At global level available evidence from the U.N (2002a) and FAO (2003a) suggests that the HIV/AIDS epidemic continues to exact a devastating toll on individuals and families and that, in countries that are hard hit, it is erasing decades of health, economic and social gains, reducing the life expectancy by decades, slowing economic growth, deepening poverty, and contributing to chronic food shortages. They also point out that AIDS is a tragedy for the individual men, women and children who are directly and indirectly affected by it, and presents a threat to the livelihoods of households, communities and ultimately the country as a whole. According to Barnett and Whiteside (2002), the epidemic has profound implications for economies in affected regions, as primary wage

earners and caregivers fall sick, require care and eventually die, usually consisting of individuals of prime working age.

The United Nations (1995) reported that the effects of HIV/AIDS is felt by all population sub-groups, however some sub-groups population such as the elderly women, are more vulnerable as they are left alone to take care of their grandchildren following the death of their children from AIDS. According to a study that the UNFPA (1999) commissioned in India, it was found that older women, particularly those living in rural areas, are often the poorest and most vulnerable group. Laslett (1997) pointed out that worldwide, the elderly women face myriad and interrelated factors: grief for their dead adult children, fear about the future of their grandchildren, if they had any, distress about the worsening economic circumstances, fear of infection and above all, who takes care in case the grand mother herself died.

According to Wachter, Knodel, and Vanlandingham (2002), although HIV prevalence is only 2% in Thailand, between 8% and 13% of the Thais older than age 60 years will experience the loss of at least one adult child to AIDS. Furthermore, the epidemic in Thailand has increased by 70% the chance that an older person, during his/her lifetime, will lose an adult child compared to if there was no AIDS. They also asserted that older women in Thailand are intensively and extensively involved with their infected adult children through both living and care giving arrangements and that two thirds of adults who died of AIDS either lived with or next to their mother at the terminal stage. Similarly, the results of another study carried out by Bor et al (1993) in India indicated that two-thirds of adults who died of AIDS received at least some personal care from the mother, and that mothers are more likely than fathers to provide at least some personal care, and 3 to 5 times as likely to be a main personal care giver.

Smith (2002) pointed out that, in many countries elderly women are the carers, producers and guardians of family life. This means they bear the largest AIDS burden and that providing care to an AIDS patient is arduous and time consuming, even more so when it is done on top of other household duties.

2.1.2 Africa

Chirume (1998) and Best (2002) pointed out that HIV/AIDS is changing the age profile in the African countries with high rates of infection, putting severe pressures on older women and placing multiple burdens upon them at a time of ever decreasing resources, and that older women have become primary carers for their children who are with HIV/AIDS, and this responsibility falls prematurely on these older women.

Zimmer and Dayton (2003), and Population Council (2003) on the detrimental consequences of the AIDS epidemic for older people in Sub-Saharan Africa, suggested the need to investigate their characteristics, living situations, and well being. They examined the living arrangements of persons aged 60 years and above in 16 countries and the tendency of the elderly women to live with children and grandchildren, as well as distributions and determinants. Results showed that older people in Sub-Saharan Africa live in a variety of household arrangements. Older men were more likely to live in a nuclear household; while older women were more likely to live in extended families with either their sons or their daughters. A similar research was conducted in Botswana by Akinsola (2000) and Apt (1996) in Ghana, and the findings indicated that elderly African women tend to live in vertically extended families, particularly with their married sons. The studies showed that the co-residence of the elderly with their adult children contributes substantially to the well being of the elderly. They also observed that if adult children lived elsewhere, for migrant labour or other reasons and, if they develop AIDS, most will return to their parental home to be cared for by a parent until they die

Studies carried out by Help Age International (2003c), in Kenya, and Mutangandura (2000) and Muperadziswa (1997), in Zimbabwe, revealed that in Kenya two thirds of all those affected with HIV/AIDS are nursed at home by their mothers in their 60's and 70's and in Zimbabwe 74% of the older carers in the sample were women.

Studies conducted in South Africa by Bachmann and Booysen (2003), and Kamwengo (2002) on AIDS affected elderly women headed households, found that fewer than half had running water in their dwellings and almost a quarter of these women in rural areas had no toilets. They proved that a care givers burden is very heavy, especially when water must be fetched from a distance and sanitation and washing chores cannot be carried out in or near the home.

According to the United Nations (2002b) and Hunter and Williamson (1997), children orphaned by AIDS are found in almost every country of the world and that in Africa, there are millions. They also observed that all these orphaned children have suffered the tragedy of losing one or both parents to HIV and AIDS, and many are growing up in deprived and traumatic circumstances, without the proper support and care.

UNAIDS (2002) reported that by the end of 2001, 12% of the children in Sub-Saharan Africa were orphans. This is almost double the proportion of orphans in Asia (6.5%) and more than double that found in Latin America (5%). Much of this difference in numbers of orphans is attributed to HIV/AIDS. In Sub-Saharan Africa, the number of orphans has increased to 34 million over the last two decades. Of these 11 million (32.3 %) are due to HIV/AIDS related deaths. Furthermore it is estimated by UNAIDS, that by the year 2010 about 42 million of all children in Sub–Saharan Africa will be orphaned by HIV/AIDS. Statistics reveal that the impact of HIV/AIDS will be felt even more acutely in countries with smaller populations but with high HIV prevalence rates like Zambia, Zimbabwe, Uganda, Malawi, Lesotho, Swaziland and Botswana.

WHO (2002) and Beckerman (2002) observed that the worst orphan crisis was in Sub-Saharan Africa, where 12 million children had lost one or both parents from AIDS and that a parent's death deprives the children of the learning values they need to become socially knowledgeable and economically productive adults. They also pointed out that this breakdown in intergenerational knowledge may play a part in a country's economic decline.

Bailey,M. (1992) and Ainsworth and Filmer (2002) stated that staying in school offers orphaned children the best chance of escaping extreme poverty and its associated risks. They also pointed out that ensuring access to education is critical in responding to the orphan crisis. Furthermore, orphans often fall behind or drop out of school; thus compromising their psychological development and future prospects; this also affects a country's long-term recovery from the epidemic. Research conducted in Tanzania by UNAIDS (1998) revealed that the school attendance rate among orphans who were being looked after by their grandmothers was only 71%. Begle (1998) believed that preserving some sort of family life is extremely important for the children who have lost their parents to AIDS even if they were being looked after by their grandmothers. Furthermore old women are shouldering much of the burden of the orphan crisis and often with few resources. A study carried out in by UNAIDS (2000a), Jazdowska (1992), and Rugalema (1999) in Zimbabwe showed that almost half of the country's orphaned children live with their grandmothers, and that in the early days of the orphan crisis, countries such as Zimbabwe built a number of orphanages. But it quickly became apparent that the orphanage solution was unsustainable and conflicted with a child's fundamental rights to grow up in a family environment. The results of these studies also found that the work load of older women in many households affected by HIV/AIDS has subsequently increased, as they have assumed the role of primary carer for sick children and orphaned children, and that the grandmothers caring for people living with HIV and AIDS, and orphaned grandchildren have a deep sense of responsibility to keep the family together, even if it is at a high personal cost to them. They also reported that the responsibility for care falls on grandparents, usually the grandmothers. Furthermore, the analysis indicates that orphans are, if anything cared for better by their grandmothers than any other carers. A similar study conducted by Sackey and Raparla (2000) in Namibia revealed that the percentage of orphans living with grandmothers increased from 44% in 1992 to 61% in 2000, with a relative drop in those living with other relatives.

UNICEF (2003) also reported that a study conducted in South Africa found that grandmother headed households include a higher proportion of orphans than grandfather headed households. UNICEF further observed that in countries such as Botswana,

Lesotho, Namibia, and Zimbabwe, where the HIV prevalence rates are among the highest in the world, it is the period between now and 2015, the date set for the Millennium Development Goals, which is likely to see the highest number of deaths in adults of reproductive age. This they reported will leave a larger proportion of older people and children to make up the core of families and communities dealing with impacts of HIV/AIDS.

2.1.3 Zambia

The UN (1991) asserted that in Zambia as in most countries throughout Sub-Saharan African, women and men, old and young, are adapting their way of life to enable them to cope with the impact of the illness and deaths of adults in their most productive years. A survey in Zambia by WHO (1999) found that most of the respondents who reported ever caring for people living with HIV and AIDS were in their 40's and older. A study by CSO (1997) of 135 female HIV/AIDS patients from Mansa hospital in Zambia found that almost two thirds were cared for by a female relative, mostly their mothers. They also found that most who reported ever caring for a person living with HIV/AIDS were aged 40 years and above.

Serpell (1996), and Foster, S. (1993) pointed out that children who grow up without adequate education are less socialized and become less productive members of society. Furthermore, the lack of education will hamper their chances of finding formal sector employment and in a country like Zambia which increasingly requires educated and technically capable people; this lack of human capital will be a national constraint.

2.2 The Socio-Economic Effects of HIV/AIDS on the Elderly Women

This section discusses literature on the socio-economic effect of HIV/AIDS on the elderly women

2.2.1 Global Level

At global level FAO (2003b) reported that the premature death of large numbers of the adult population at ages when they have already started having children and become economically productive can have a radical effect on virtually every aspect of social and economic life. FAO further observed that, for mothers of AIDS infected adult children, its effects are manifested in the caring for AIDS orphans, financial demands, physical and health impacts, economic and social opportunity costs, and emotional impacts.

Research in the Caribbean Nation States conducted by Serow and Cowart (1998) on chronic poverty dynamics suggest that shocks such as those due to an illness like AIDS are among the factors that drive the poor and many who may have initially been better off into long- term poverty. Akintola and Quinalan (2003) and WHO (2001), reported that AIDS causes household expenditures to rise as a result of medical and related costs, as well as funeral costs. They also observed that AIDS affected households appear more likely to suffer severe poverty than non-affected households, and older women who lose their adult children to AIDS are exceptionally prone to destitution. Olson (1994) stated that older women generally suffer most from chronic poverty and lack of resources. Furthermore, they are often in need of care themselves, but face, sometimes unaided, the costs and emotional stress of nursing terminally ill adult children, paying for burials, and the financial and practical difficulties of bringing up orphans, including paying school fees.

In Thailand studies conducted by Bloom and Goodwin (1997) revealed that the opportunity cost of care giving in terms of curtailing of economic activities was very high for low income groups, thereby indicating that AIDS leads to impoverishment.

Furthermore poverty resulting from such a situation can be categorized into two types, namely, service poverty, where people are unable to access services such as health and education, and resource poverty, because of inability to access resources due to poverty with respect to rights and representation or governance.

2.2.2 Africa

Ainsworth and Over (1994), Corrie (1997), ILO (2000), and Cohen (2000), reported that growing poverty in many developing countries, particularly Sub-Saharan Africa, is exacerbated by the impact of HIV related illnesses on young and middle aged adults in the household, and that if the infected individual is the sole breadwinner, the impact is especially severe. They also claimed that the strength of the household in managing the impacts of the loss of an adult child in the household depends on the economic base and those households that have higher incomes or better alternative resources are able to cope with the impact of an income shock such as HIV/AIDS.

Foster, G. (2002), World Bank (1999), Stoukal (2001), and Baier (1997), stated that in Africa on average, AIDS care giving expenses can absorb one third of a households monthly income, spending more on funerals than on medical care, and that HIV infection ultimately stretches the resources of the extended family beyond its limits as both material and non-material resources are rapidly consumed in caring for the infected. They pointed out too that once a household member develops AIDS, increased medical and other costs, such as transport to and from health care centres occur simultaneously with reduced capacity to work, creating a double economic burden on the elderly women. May (2003) in a study carried out in South Africa found that HIV/AIDS first affects the welfare of households through illness and death of the adult members, which in turn leads to the diversion of resources from saving and investment to care.

Results of a study conducted in Uganda by Williams, and Tumwekase (2001) on the plight of orphans found that grandmothers that are taking care of orphans live below the poverty line and that in 14% of the cases, a grandmother had to take on additional work

to cover these expenses, in one-fifth the older women sold property or possessions, and in almost two-fifth of the cases, they went into debt for this purpose.

Mann, Tarantola, and Netter (1992) pointed out that during planting and harvesting seasons, economic considerations often force poor families to suspend or postpone care giving to earn income or grow food for the household. Furthermore when such short-term economic considerations take precedence over continuing health concerns, it can compromise a households long-term viability. According to Over (1995), Millar (1999), Mbamaonyeuku (2001), the impact of HIV/AIDS on the macro economic environment takes two dimensions, namely the direct and indirect costs, and that the repercussions of HIV/AIDS is felt most acutely at the household level, with the burden weighing most heavily on the poorest household, those with the fewest resources with which to cushion the economic impact. They also observed that the situation of many older women living in developing countries is one of extreme poverty and exclusion. Furthermore, they often lack access to adequate and affordable health care and other basic requirements, especially in rural areas and some are also confronted with financial emotional and physical abuse. Seale (1990) and Hedstrom (1997) stated that most old women in the hardest hit countries face heavy economic, cultural, and social disadvantages which increase their vulnerability to the epidemics impact and that the elderly women are likely to be the most active persons to manage the agricultural and other family affairs in the event of the death of the adult children. They also asserted that a death in the rural household as a result of AIDS can have profound implications for agricultural resource allocations, production, consumption, savings investment, and well being of the surviving grandchildren who are orphaned by AIDS, and that this condition is likely to impoverish the rural elderly women.

The World Bank (2003) and Ogden, et. al. (2004) observed that households often reduce spending on food, housing, clothing, toiletries, to cover increased AIDS-related medical costs, and that orphans living with their old grandmothers are more likely to be malnourished, underweight, or short for their age in comparison to non orphans.

Bailey and Turner (2002), and Ferriera (2001) observed that in South Africa, where these elderly women had some income, they often denied themselves the little they got to feed the family, exposing themselves to problems of food deprivation and that women who are 60 years and above who receive the social old age pension, extend the greater part of their grant income on meeting the needs of AIDS sick adult children and affected grandchildren.

The UNDP (2001) reported that In Uganda there has been a 47 percent increase in support by extended families. The safety net provided by the extended family is identified as the most effective community response to the AIDS crisis, and older women are increasingly heading these extended families, but their capacity is stretched due to lack of resources, breakdown of traditional support mechanisms, migration and AIDS.

Linsk (1994) and Oxfam (1998) pointed out that older women trying to access resources are blocked by discriminatory laws, traditions, customs, and values and that it is important to assess the impact of HIV/AIDS on elderly women because they have limited work opportunities due to capital, age and educational constraints. They also stated that poverty is especially acute for older women who in many societies in Africa are traditionally not entitled to own property. Furthermore, there are relatively high levels of illiteracy among older women in Africa, and the education offered to generations born in the first third of the twentieth century tended to reinforce, rather than challenge, ideas of them as wives and mothers and that, female poverty at the end of life is a consequence of all the inequalities a woman has endured since birth.

According to UNICEF (2003) in Zimbabwe, in rural areas where there is an AIDS patient, the average household income dropped between 52-67%. Expenditure on children was halved, and food consumption dropped by 41% and the older people were coping with physical, social, economic, and psychological burden of caring for their dying children and raising orphans. Furthermore, the demise of their support base coupled with the absence of any formal pension, results in a situation where older people

are orphaned in reverse. This study tries to find out whether this theory is similar or different in the rural areas of Zambia.

The results of a study in Uganda by Cattell (1997) indicated that up to 33.6% aged above 50 years are providers of education to grand children after their parents (children of the aged) have died of HIV/AIDS. This research also revealed that these elderly women with income that can hardly support their daily basic needs have an extra burden of providing basic needs for the orphans. These deaths are occurring mostly within the active and the economically productive age group (15-49 years), leading to expected falls in rates of economic growth between 15 to 25 percent, over a 20 year period. Furthermore the loss of the bread winners leaves no reserves for the family to cope with; this directly affects the risk management capacity of the other persons involved. African Union (2002) reported that, in spite of these hardships older people especially women in Sub-Saharan Africa, provide not only health care and support for the infected, but are also responsible for financial support, emotional support and child rearing of the orphaned grandchildren, both HIV positive and HIV negative.

UNIS (1995) reported that stories were told in those early days, and pictures shown, of villages in Uganda where entire populations of young adults were decimated by AIDS (the slim disease) leaving only the most elderly, caring for the young. This impact is still being felt to date, as grandmothers have had to re-learn parenting all over again in order to cope with the so called AIDS orphans that are left in their care. UNIS further observed that qualitative research in Tanzania, Uganda, Kenya, and Zimbabwe all stress the importance of parents in caring for AIDS afflicted adult children, but provide no basis for quantitative assessments. There are also clear indications that mothers play a more important role in personal care than fathers.

Du Guerney (2001) and Mba (2002) argued that the role of elderly women in rural development in the context of the HIV/AIDS epidemic has been neglected and that the elderly women can play a crucial role, not just in care giving but in ensuring the food security of millions of affected rural farm households. Furthermore, the elderly women

are a largely invisible resource in the context of HIV/AIDS requiring assistance and empowerment in order to fulfill their indispensable potential to play a pivotal role of holding together households, ensuring food security and survival of orphans. According to Ginn (1991) elderly women have come to the fore in studies of informal care, but are cast as passive recipients, their own role in caring for kin and others being mostly neglected. Studies by Help Age International (2002b) in South Africa and in rural Uganda reported the lack of recognition and support given to the older women to sustain this care and support role

2.2.3 Zambia

Haworth (1991) stressed that one of the striking features of economic impacts on affected households in Zambia is the rapid transition from relative wealth to relative poverty. Furthermore, the shift into poverty was most visible in families in which the deceased father was the breadwinner. Baylies (2002) in a study in Zambia stated that lack of financial capital and saleable assets is a major part of poverty, often compounded by a lack of social support, skills and education.

According to UNAIDS (1998), a study in Kafue estimated that households experience a decline in income between 48 percent and 78 percent when a household member dies from AIDS, excluding the cost of funerals, and another study conducted by Chingambo (1995) in Zambia on AIDS-affected households found that monthly income fell by 66%-80% due to coping with AIDS-related illness. A review of the financial status of 60 families in Zambia by CSO (1998) revealed a common pattern in which there was a considerable drop in the income level and/or family assets following the death of the father. Furthermore, the magnitude of this drop was dramatic, consisting of a reduction of monthly disposable income by more than 80% for more than two thirds of the families.

Research evidence from a study conducted in Zambia by UNDP (2002) indicated that among the poor in Zambia are the small scale farmers and people living in low cost areas, especially older women. Furthermore, the poorest economically active households rely

2.3 The psychological and physical effect of HIV/AIDS on the elderly women

This section discusses literature on the psychological and physical impacts of HIV/AIDS on the elderly women.

2.3.1 Global Level

According to HelpAge International (2003b), globally the combined physical and emotional stress resulting from the persisting needs of sick household members, while trying to secure the basic means for survival, inevitably forces women to neglect their own health. They also pointed out that from the social point of view HIV/AIDS places enormous stress on infected individuals and their families who are confronted with the demands of caring for the seriously ill and with the psychological trauma of death

2.3.2 Africa

Emotional stress over the adult child's suffering and decline during illness and grief following the child's death are universal. Studies conducted by World Bank (1994) in various countries in Sub-Saharan Africa, indicated that the death of an adult child is among life's most emotionally distressing events, and that the aged are finding themselves in the role of caregivers to grandchildren and that such care is both physically and emotionally damaging especially for the frail elderly women who may find themselves to be physically impaired. According to Adamchack (1996) and Gorman (1995) also indicated that AIDS even more than other causes of young adult death, can compound parental misery because of intense suffering of ill son or daughter, especially during the terminal stage, and the accompanying stigma that is sometimes attached to the illness. From their point of view, the health of older-aged women could suffer through physical strains from care giving, extra work taken on to pay expenses, and /or potential exposure to the opportunistic diseases (especially T.B) that the person living with HIV/AIDS often contracts.

Studies conducted in Tanzania by Appleton (2000) and Ainsworth and Dayton (2003) revealed that the physical well being of the elderly women as measured by body mass index, reduced before the death of an adult child (during the illness), and that the physical well being of the elderly women in poor but better off households prior to an adult's death is compared with that of the elderly women in the poorest households that did not experience the death of an adult child. The comparisons indicated clearly that the elderly women from poor households taking care of a sick adult child infected with AIDS, have the lowest body mass index. Furthermore, apart from being under financial and economic pressure, older people caring for sick adult children and orphans are also suffering from immense physical and emotional stress resulting from having to deal daily with these new and unfamiliar roles and that there are no structures in the health systems or in the social fabric, to help them manage the stress. Similarly FAO (2001) reported that a study in Zimbabwe found almost two-fifths of older age carers stated that they had experienced physical illness after the death of the adult child under their care.

2.3.3 Zambia

Drinkwater (1993) in a study conducted in Zambia on elderly women's health status found that almost two- fifth of older age carers reported that they had experienced physical illness after the death of the adult child under their care.

2.4 The Elderly Women's Coping Mechanisms

This section reviewed literature on the elderly women's networks for survival.

2.4.1 Global Level

Suaerborn, Adams, and Hein (1996) pointed out that, globally, withdrawing children from school is a short-term strategy that has permanent effects that could make it difficult to reduce poverty in the long-term. In Cambodia a recent study by UNAIDS (2000b)

found that about one in five orphaned children in AIDS affected families reported that they had to start working in the previous six months, to help their grandmothers in supporting the family. One in three had to provide care and take on major household work. Many had to leave school, forego necessities such as food and clothes, or be sent away from their home. All the children surveyed had been exposed to high levels of stigma, discrimination, and psychological stress, with the girls more vulnerable than the boys.

A study conducted in India by USAID (2001) found that the burden of health care in India is inversely related to economic status of the household resulting in poor households becoming victims of an inefficient health care system. The study also revealed that the poor had greater problems in accessing treatment, leading them to adopt various coping mechanisms, like selling of assets. Furthermore, many resorted to home based activities such as vending to earn extra money to support medical expenditure.

2.4.2 Africa

Kelso (1994) asserts that traditional coping mechanisms offered by the extended families are frequently overwhelmed, leaving both orphans and grandmothers in great need of assistance and that specifically orphans needed physical, emotional, and vocational skills, health care, and assistance in coping with avoiding stigmatization, exploitation, and socialization.

A study conducted in Ghana by Ahenkora (1999) revealed that besides taking care of grandchildren who are orphaned by AIDS, the elderly women also engaged in agricultural work. Furthermore, it was found that in most activities in the rural areas, the roles of these elderly women were not statistically different from those of their younger counter parts. HelpAge (2002a) also confirms that the elderly women often make long journeys to the markets, sometimes with grandchildren on their backs, carrying heavy head loads of farm produce to sell.

According to Barnett and Blackie (1992), AIDS creates extraordinary care needs that must be met, usually by withdrawing other household members from school or work to care for the sick, and that intensive use of child labour increases as a major strategy typically used by the elderly grandmothers. Beegle (2003) reported in a study conducted in Tanzania that about 13% of older school age children in families where someone was ill or died of AIDS were withdrawn from school to help support the family.

Studies conducted in Bukina Faso and Tanzania by Lwihula (1999) revealed that rural households responded to serious illness and bereavement by selling livestock, and reorganizing household labour, and that the illness affects time allocation, puts pressure on the elderly women and children to work, diverts household cash, and leads to the disposal of household assets. Furthermore asset liquidation usually begins with the sale of non-essential items, but can quickly progress to selling key productive assets.

2.4.3 Zambia

In Zambia a study by De Bruyn (1992) found that not only was reducing on consumption of meals common in all rural areas as a coping mechanism, but that it was more common in households with an HIV/AIDS infected adult. For example, 57% of such households had gone entire days without eating in the preceding two months.

The literature that was reviewed above on studies carried out in various countries throughout the world indicated that HIV prevalence will continue to rise beyond levels previously thought possible worldwide. This means extraordinary multisectoral responses in affected countries are needed more urgently now than before. UNAIDS (2003) reported that more than 40% of countries with generalized epidemics, have yet to evaluate the socio-economic impact of AIDS on the elderly women, and that this hinders essential efforts to mitigate the epidemics consequences on these elderly women.

These studies also revealed that the death of an adult child can have a dramatic impact on family structure and function. The elderly women may be left to run households with

severe implications for those concerned and that there is now an urgent need to research the effects of HIV/AIDS on older women and their crucial role as carers, and to support them as key contributors to community survival

Therefore the literature reviewed indicates that HIV/AIDS will continue to be a global problem and that few studies have been carried out on its impact on elderly women. In Zambia literature in this field is very sparse. This shows that there is a gap in this area of research and an urgent need to help develop programmes that may mitigate the impact of HIV/AIDS on elderly women.

CHAPTER THREE

RESEARCH METHODOLOGY:

3.0 Introduction

This chapter presents the research design of the study. It discusses the sources of data and instruments used for data collection. The chapter also outlines the problems encountered in the collection of data.

3.1 Research Design

The study adopted the descriptive research design. The study was undertaken to examine the effects of HIV and AIDS on elderly women aged 60 years and above in the rural areas of Zambia, a case study of Chongwe rural. The study was undertaken between August and September 2005. The study utilized the qualitative research technique. This approach was used so that the researcher could record the spoken words of the participants. This method also enabled the researcher to observe the participants behaviour and record it accurately. The participants were also studied in their natural environment, that is, the elderly women at their homes and the key informants in their offices. This was an advantage because the participants were able to express themselves freely to the researcher. Employing qualitative methods was useful also in providing an in-depth understanding of the situation of the elderly women in the study

3.2 Research Site

The study was conducted in Chongwe rural which is situated 45 Km east of Lusaka. The district population in the 2000 census was 144,736 which were 1.4% of the total National population and 10.1% of the population of Lusaka province. The choice of this area was

based on the existing high prevalence rate and high mortality rate of men and women in their productive age (19 years-49 years old). According to Central Statistics Office the total number of people with HIV and AIDS in Chongwe is 13,215. One of the major contributing factors to the high rate of infection is that, the district has a highway- Great East road which exposes people to high risk behaviour because of the interaction with truck drivers traveling from the neighbouring countries (Malawi, Mozambique, and Zimbabwe). Most of the population is rural, with inadequate health facilities such as VCT centres and home based care services.

3.3 Population and Sampling

Twenty (20) elderly women were identified from the Home Based Care projects and the Churches from where they were registered as caring for people living with HIV and AIDS in their homes by using a screening form. These women were either caring for a sick adult child who was infected with HIV and AIDS or had recently experienced the death of an adult child from HIV and AIDS. The conditions were self reported without medical confirmation. Included among the participants were five (5) key informants, one (1) Government official from the Ministry of Community Development, three (3) representatives from three Non-Governmental Organisations, namely, World Vision, Christian Children's Fund, and Facing the Challenge of AIDS, and one (1) church official from the Catholic Diocese.

3.4 Data Collection

Data for the study was collected by one on one semi-structured, in-depth interviews with the twenty five (25) participants. The researcher herself was the main instrument in the research process. She made critical observations of the participants' non-verbal communication and recorded them down. The interviews were also recorded on the audio tapes. This was to enable the researcher to get and write down the actual words and tone that were spoken by the participants, since the interview was being translated from Soli, and Nyanja languages into the English language.

Interview guide (A) was used to find out the social, economic, psychological, and physical effects of HIV and AIDS on the elderly women, and also to find out what their coping mechanisms were. Interview guide (B) was used to assess the roles played by formal support structures such as the Government, NGOs and the Church in assisting the elderly women.

3.4 Data Analysis

Data from the interviews with the elderly women and key informants were transcribed and analyzed by coding them into themes that emerged. The information from audio tapes was equally transcribed by the researcher and one of the research assistants who are fluent in the Nyanja and Soli languages. Themes that emerged formed the basis for data categorization. This information is also presented in the form of tables and pie charts.

3.5 Problems Encountered During Field Work

The researcher encountered a number of problems during field work. In spite of having obtained permission from Chieftainess Nkomeshya to conduct the research, some of the NGO representatives refused to be interviewed because there was no permission granted to the researcher from their Secretariats in Lusaka to interview their members of staff in Chongwe. However the researcher managed after two weeks to locate other NGOs who were cooperative.

Some parts of Chongwe are characterized by steep hills, escarpments, and valley areas. This was a problem because it made it difficult for the vehicle to pass. In such cases the researcher and her team, had to park the vehicle at the foot of the hills and walk for some distance. This delayed the interviewing process because fewer participants would be interviewed per visit, sometimes two participants were interviewed in one day.

The other constraint faced was time. A large amount of time was spent trying to trace these elderly women, some of them were difficult to interview in that they were not at

home despite repeated visits being made which meant they had to be replaced by other participants after attempts to find them home had failed.

Another problem was that the distance between the villages was long, so it would take some time to get from one village to another.

One elderly woman simply declined to be interviewed because she believed that talking about AIDS was the same as gossiping. However, the researcher attributed her attitude to stigma and a replacement was found.

Lastly, the researcher is a self sponsored student, and therefore had some constraints on financial resources. The main issue was that, most of the time the researcher was in the field the participants complained of not having enough food to feed their patients and the grandchildren. In some cases the situation was so heart breaking that the researcher with her limited resources started carrying food packages consisting of a small packet of *kapenta*, salt, and dry beans which were distributed to the participants after each interview session.

CHAPTER FOUR: FINDINGS AND DISCUSSIONS

4.0 Introduction

This chapter discusses the findings of the study. Section 4.1 discusses the social backgrounds and characteristics of the elderly women. Section 4.2 discusses the elderly women's knowledge and perception of HIV and AIDS. Section 4.3 highlights the socio-economic impact of HIV and AIDS. Section 4.4 provides an analysis of the psychological impact of HIV and AIDS on the elderly women. Section 4.5 highlights the effect of HIV and AIDS on the physical well being of the elderly women. Section 4.6 discusses the elderly women's coping mechanisms. Section 4.7 provides an analysis of the role played by the formal support structures such as the Government, Non-Governmental Organisations and the Church.

Survey Area

Interviews were carried out in Lusoka, Kapuka, Sheleni, and Chikwela villages. A total of 20 (twenty) elderly women were interviewed as follows; 6 from Chikwela village, 5 from Kapuka village, 4 from Sheleni village, and 5 from Lusoke village. All these villages are located in different zones under Nkomeshya's chiefdom. The Catholic Church leader, the project managers of World Vision, Christian Children's Fund, Facing the Challenge and the government officer from Ministry of Community and Social Development were all interviewed at their offices in Chongwe District.

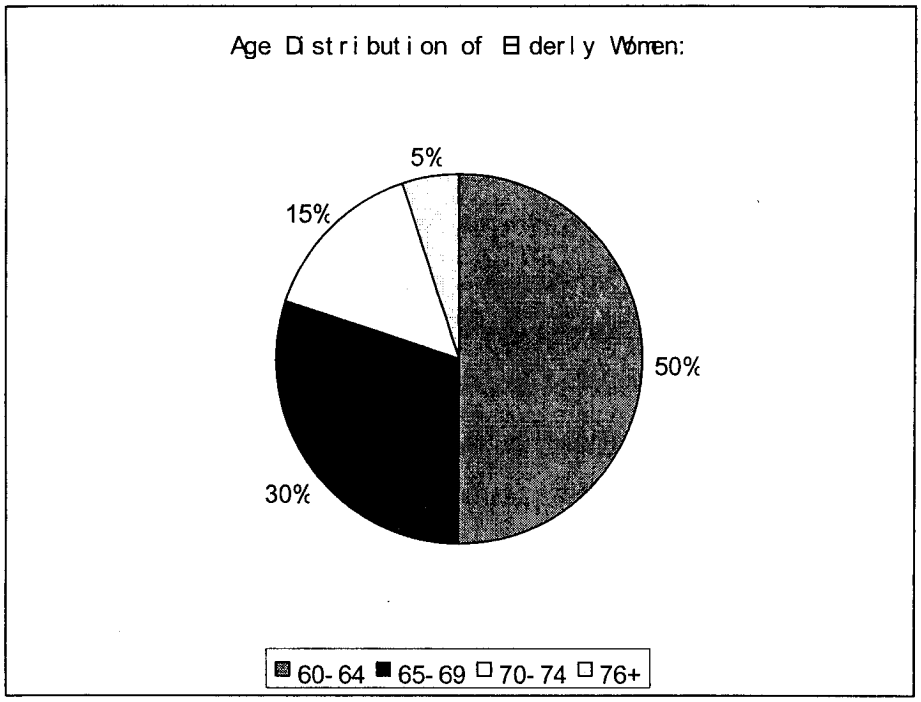
4.1 Background Characteristics of the Participants

The background characteristics of the participants interviewed in the study are presented in this section.

4.1.1 Age

According to the findings, the age range of the 20 elderly women interviewed was 60 to 76 years, 50% of the women were aged between 60 to 64 years, 30% were aged between 65 and 69 years, 15% were aged between 70 and 74 years while only 1 participant was 76 years old. Therefore the majority of participants, 80% were aged between 60 and 69 years old. All these elderly women had national registration cards in their possession making it easier for the calculation of their ages. The results of the findings are illustrated in figure 1.0.

Figure 1:0



4.1.2 Marital Status

The findings show that out of the 20 elderly women interviewed, 60% were widowed, 30% were divorced, and 10% were single and had never been married but they had children. Out of the 12 widows, 8 explained that they had started living with their adult children after their husbands had died and 4 reported that they moved into their son or

daughters home when their adult child had become seriously ill and they needed to care for him/her. An explanation for widowhood could be that generally women live longer than men and that due to early marriages in rural areas there are more widows than widowers. According to the Zambia Demographic Health Survey, the life expectancy at birth for men in Zambia was 50 years in 1980 and was estimated to have declined to 48 years by 2000, and Zambian women were expected to live on average four years longer than men. In the same survey, on the population distribution according to sex and urban-rural residence, the data showed that there were slightly more women in Zambia, constituting 51% and men constituting 49%. The data also revealed that in the rural areas 5.8% were elderly women aged between 60 and above as compared to 4.1% elderly men (CSO, 2003).

All these women reported that they were now heads of their households because of the illness or the death of their adult children who had been the sole breadwinners and that they were now wholly responsible for the day to day running of their households. The results of the findings are shown in Table 1.1.

Table 1.1 Distribution of elderly women according to their marital status:

Marital Status	Number of elderly women	Percentage N =20
Never married	2	10%
Divorced/Separated	6	30%
Widowed	12	60%

It was discovered during the interviews that 80% of the participants belonged to the Soli tribe. This ethnic group follows the patrilineal system of kinship, and 10% belonged to the Bemba tribe, the other 10% were Tongas. The Bemba and Tonga women reported that they had been married to men who belonged to the Soli tribe. When women are widowed in a patrilineal society they lose rights to property. If a widow does not marry her husband's brother, she loses access to her husband's property. Many customary tenure systems provide little independent security of tenure to women on the death of

their husbands, with land often falling back to the husband's lineage. This means that traditional mechanisms to ensure women's access to property in case of widowhood contribute to the old women going to live with their sons or daughters after the death of their husbands. In Zambia the Inheritance Bill was passed but many of the women in the rural areas are ignorant about it. This is because they have not been sensitized about its contents and the advantages of this bill.

4.1.3 Education Level

According to the results shown in Table 1.2 below, data revealed that 70% of the participants had never gone to school and 30% had reached Standard three which is equivalent to Grade Five (lower primary level), and dropped out of school before completing that level. None of these participants entered secondary school or any colleges. This supports data from CSO (2000) which shows that in Zambia younger women are more likely to have attended school than the older ones, 92% of women aged 15-19 and 20-24, respectively, 78% of those aged 45-50 years compared with only 30% of women aged 60 and above in the study. The results of the study show that the majority of the elderly women, 70% were uneducated which means they never received any formal education.

Table 1.2 Distribution of Elderly Women According to their Educational Attainment:

Educational Attainment	**Number of Elderly Women**	**Percentage N=20**
Not Educated	14	70%
Primary Level	6	30%
Secondary Level	0	0
Higher Level	0	0

4.1.4 Religion

Data shows in Table 1.3 that 90% of these elderly women were Christians and that 10% were non Christians. Out of these participants 50% were members of the Catholic Church, 20% participants worshiped at the United Church of Zambia, 5% with the Pentecostal Church, 5% with the Baptist church, 10% reported worshiping at the New Apostolic Church and 10% said they were not members of any church because they did not believe in the Christian God but in ancestral spirits.

Table 1.3 Distribution of elderly women according to their religion:

Religion	Number of elderly women	Percentage N= 20
Catholic	10	50%
United Church of Zambia	4	20%
Baptist	1	5%
New Apostolic	1	5%
Pentecostal	2	10%
Not going to church	2	10%

The results of the study indicated that the majority (90% of the participants) were practicing Christians who were registered and active members of their respective churches. This implies that religious participation was very popular among most of the elderly women that were interviewed. The reason for this could be that, under conditions of illness, bereavement and economic crisis, religious activities and participation increased. The findings agree with Doyal (2001) who stated that the need to supplement inadequate material resources by spiritual means was quite rational, and religious participation could be seen as a search for reassurance in a situation of constant stress and distress.

The church going women reported that they valued the care, nutritional support, fellowship, and reassurance they got from the church, which increased their will to survive and cope with difficult times.

4.2 Elderly Women's Knowledge and Perception of HIV/AIDS

During the study the participants were asked if they had ever heard of the disease called AIDS and if they could mention ways to avoid contracting HIV/AIDS.

4.2.1 Elderly Women's Knowledge of HIV/AIDS

Data on the participant's knowledge of the disease called AIDS shows that all 20 of them had heard about this disease called AIDS.

4.2.2 Elderly Women's Knowledge of ways of Prevention of HIV/AIDS

The results of the study show that when asked to mention ways of prevention of AIDS, all the 20 participants reported that by limiting the number of sexual partners people would avoid contracting the disease. They emphasized that if women and men stopped having sexual intercourse with multiple partners the rate of infection would reduce in the area. They also complained that there were some married men and women in Chongwe who were very unfaithful to their spouses and that if every body remained faithful to each other and had sex with only one partner this disease would not spread. Some of these women said that they knew more than one way of avoiding contracting the disease. 30% of the participants said that besides men and women limiting their sexual partners, a man can avoid contracting HIV/AIDS by not having sex with a woman or girl that has had an abortion, 40% of the participants included avoiding sharing the same plates, cups, and spoons, 25% mentioned that AIDS would not be transmitted if people avoided shaking hands with someone who is infected with AIDS, sharing food, clothes, cups, spoons and plates, and 5% reported that besides limiting the number of sexual partners, people should also avoid sharing the same toilet with an HIV/AIDS infected person.

From the results of the study it shows that the participants' understanding of the nature, cause, and transmission of HIV and AIDS is limited. The cause of this may be attributed to the fact that they never attended any HIV and AIDS awareness programs since it was only the younger people of reproductive age who were targeted by these programs. The little knowledge they had about the disease, they had obtained from the health care workers. They explained that the younger children could not discuss any topics about sex because it was traditionally a taboo to discuss sexual issues with young people. The results of the study also show that all these elderly women fear that they or the other family members can contract the disease but because they lack accurate information about its mode of transmission and prevention they choose to believe the myths and misconceptions about the disease. When the participants were asked if they used any protective clothing when they were handling blood products, they all answered that they used their bare hands and that they did not use any gloves.

The findings of the study also revealed that lack of information about HIV/AIDS and its consequences exposes elderly women to infection through their role as carers of people infected with HIV/AIDS. The exclusive focus on younger men and women in their reproductive years in HIV/AIDS education campaigns ignores the need to educate elderly women on the advantage of wearing protective clothing such as gloves when handling blood products to prevent infection.

4.3 The Socio-Economic Impact of HIV/AIDS on the Elderly Women

4.3.1 Elderly women's role as carers of HIV/AIDS patient

Results of this study indicated that 70% of the participants had recently suffered the loss of an adult child from HIV/AIDS within the last twelve months and 30% of the participants were nursing an HIV/AIDS infected adult child. It was observed that elderly women have become the primary carers of their adult children who are sick with HIV/AIDS in that even those who had lost an adult child from HIV/AIDS reported that they had cared for the adult child during his or her long illness. Some of these elderly

women (45%) indicated that they had moved in with their adult children when they became widowed or divorced and the elderly women who had never married but had children mentioned that they moved in with their children because they were old and needed someone to support them in their old age. 55% of the participants mentioned that their adult children returned to the village when they became seriously ill with HIV/AIDS. Therefore in this case substantial return migration of ill adult children helps to explain the high level of these elderly women's care giving tasks. This means that unless the adult child who was ill was married and his or her spouse remained with him or her to provide care and support, he or she would often have nowhere else to go. Zambian hospitals shy away from long-term care, and AIDS hospices have limited capacities. Moreover, there are strong personal emotional advantages of being at home to die.

This study supports findings of studies carried out by Help Age International (2003c) in Kenya, and Mutangandura (2000) and Muperadziswa (1997) in Zimbabwe, the results revealed that in Kenya two thirds of all those affected with HIV/AIDS are nursed at home by their mothers in their 60's and 70's and in Zimbabwe 74% of the older carers in the sample were women.

Chirume (1998) and Best (2002) also stressed that HIV/AIDS is changing the age profile in regions with high rates of infection, putting severe pressures on older women and placing multiple burdens upon them at a time of ever decreasing resources. As AIDS continues to afflict young adults in Africa, it intensifies the vulnerability of the elderly women who are left without social and economic support when their children die.

4.3.2 Occupation of the Deceased and Sick Adult Child

This section provides a presentation of the occupation of the deceased or the sick adult child infected with HIV/AIDS. Table 1.4 presents data on the occupational status of the deceased and the sick adult child who was infected with HIV/AIDS.

Table1.4 Occupation of Deceased and Sick Adult Child Infected with HIV/AIDS

Occupation	Female	Male	Frequency
Farmer	0	2	10%
Businessman/Businesswoman	3	5	40%
Farm worker	3	4	35%
Casual worker	2	1	15%

Data shows that the sick patients and deceased children were either working on other peoples farms, businessmen and businesswomen, running their own farms or doing some part- time work. All the participants mentioned that their adult children were the breadwinners and supported them before the illness and the death. According to the participants the support was in the form of food, shelter, and clothing. The findings of this study support the statements by Ainsworth and Over (1994), Corrie (1997), ILO (2000), and Cohen (2000), that growing poverty in many developing countries, particularly Sub-Saharan Africa, is exacerbated by the impact of HIV related illness on young and middle aged adults in the household, and that if the infected individual is the sole bread winner, the impact is especially severe.

When asked whether they had other children besides the deceased and the ill patient, 95% of the elderly women mentioned that they had other children, and that these children were not in gainful employment, others had migrated to the urban areas in search for employment and left them uncared for. Those who were married and lived in the same village also had insufficient resources, their income was low and they did not have enough to even feed their own children. The explanation for this is that had the old women been alone they probably would have been taken in by one of their surviving children, but the major problem were the orphaned grandchildren she had been taking care of. The rest of the elderly women, 5% explained that they did not have any other surviving children. This shows that although the family is supposed to be the most important caring institution for elderly women and the orphaned grandchildren, socio-

economic changes have weakened the strength of this system to provide adequately for them.

4.3.3 Elderly women's Source of Income and Expenditure Pattern

Results of the study show that the elderly women resorted to various measures to meet the expenses associated with their adult child's illness and death. The main source of income for these participants was from informal activities and agricultural activities such as brewing illicit beer and *munkoyo*, farming on relatives land, selling vegetables, selling bundles of dry grass during the dry season, farming on other people's land, and piece work. The findings are presented in Table 1.5.

Table 1.5: Elderly Women's source of Income:

Types of Earnings	**Brewing illicit Beer and *Munkoyo***	**Farming on Relatives Land**	**Selling fruits and Vegetables, and Dry Grass**	**Farming on other Peoples Land**	**Piecework**
Cash only	15%		25%		
Cash and in Kind				30%	10%
In kind only		20%			

Some of these activities were seasonal, especially agricultural work, when people grow maize, and collecting and selling bundles of dry grass during the dry season. 20% of the participants reported that they planted, weeded and harvested on their relatives' farms and were given some *mealie meal* and some clothes as payment during the rainy season and that during the dry season they collected grass, bundled it and sold it for K1, 000 per bundle. This grass is used in the villages for thatching huts. Data shows that 15% were in the illicit beer and *munkoyo* brewing trade, 25% reported selling vegetables and fruit such

as mangos when in season and mushrooms and wild fruits and sold dry grass during the dry season, 30% reported working on other people's land who were not their relatives and performed the following chores, tilling the land, planting, weeding, and harvesting These elderly women reported that sometimes they were paid cash and other times given second hand clothes or food. 10% did some piece work like washing some clothes for people or sweeping their homes. The elderly women who reported that they sold vegetables grew these vegetables in their little backyards, some of the vegetables were consumed by the family and the excess was sold to make a living. Out of the 20 participants only 15% mentioned that they were rearing some chickens and goats.

The participants explained that they could not stay away from home for too long because they needed to care for their very sick adult children. The findings were different from the results of a study conducted by Mann, Tarantola, and Netter (1992) in Ghana which indicated that during planting and harvesting seasons, economic considerations often force poor families to suspend or postpone care-giving to earn income or grow food for the household.

The study found that the 20 elderly women were the main contributors to paying for their ill adult child's medical treatment. Participants indicated that the material needs of the people with HIV/AIDS were soap, vaseline cream, food, medication, clothing, blankets, registration and consultation fees at the health care centre and transport costs to and from the health care centre. These are easily accessible but highly unaffordable because of financial constraints. Participants also indicated that people with AIDS require healthy food that is expensive to obtain. The reason for this is that the elderly women had problems finding funds to buy the basic necessities, transport money to take the patient to the health care centre and registration fees to pay at the clinic because these have to be paid before the patient is treated. The women also experienced great difficulties in meeting medical costs and buying simple pain killers like Panadol tablets which were sometimes not available at the rural clinic where they would not have to pay for the drug. The participants who had suffered the loss of an adult child complained that they had to spend their limited resources on the funeral costs and the 30% elderly women who were

caring for a sick adult child complained that most of their money was spent on food, medical and transport costs to and from the health care centre.

All the participants indicated that the illnesses and deaths of their adult sons and daughters robbed their households of the major sources of support. All the women who mentioned that they had recently experienced the death of an adult child, or that they were caring for a chronically ill adult child, indicated that, the child was once the major source of income. This meant that when that child fell ill and died, the women and their households, which now included grandchildren, could not sustain their old consumption patterns. They were forced to cut back consumption of basic food and non-food items.

All the 20 participants complained about the lack of clean and safe water and firewood near their villages. They complained that they had to walk long distances to collect water and firewood, 20% indicated that they fetched water from boreholes while the majority of the elderly women 80% used water from other sources such as rivers, streams and wells. Persistent absence of adequate water results in poor personal hygiene and infrequent bathing and washing of clothes and bedding. From these results there is a suggestion that the physical demands placed on ageing women are enormous, especially in the rural areas where accessibility to basic resources such as water, energy, food, and proper infrastructure is limited or non-existent. On top of that, they also retain the responsibility for doing domestic work in the home.

4.3.4 Elderly Women as Carers of Children Orphaned by HIV/AIDS

The participants were further investigated to get an insight into how many of them were grandmothers and caring for at least one child orphaned by HIV/AIDS. Data shows that the number of orphans left under the care of the grandmothers ranged between 2 and 9, with an average number of orphans of 3 per household. 50% of the participants reported taking care of between 2 to 3 orphans, 35% said they kept between 4 and 6 orphans and 15% of the participants looked after more than 7 orphans. The findings of the study

revealed that all the 20 elderly women looked after orphaned grandchildren. Table1.6 shows the distribution of participants living with orphans.

Table 1.6: Distribution of number of orphans per elderly women's household:

No of orphans	No of elderly women	Percentage N=20
2-3	10	50%
4-6	7	35%
More than 7	3	15%

Information revealed from the figures tally well with the short stories from these in depth interviews with the elderly women. Two cases of grandmothers who were taking care of children orphaned by HIV and AIDS are presented below as cases 1-2:

Case 1:

One of the participants aged 70 years old from Lusoke village, complained that she was in poor health, she says "I do not eat or sleep well and I cannot see properly." Yet she cares for four grand children, a two year old girl and three boys aged 5-13 years. The children's parents both died from AIDS. "I am losing my senses now," she says. "It seems as though I do not have a soul, it has gone away. In the past my son looked after me. I was shocked when my son got sick and eventually died and I am worried about my grandchildren."

Her role has changed from being provided for to providing care and support to the orphaned grandchildren. She complained that she strains so much to meet the very basic requirements after the loss of her son who was the breadwinner in the household.

Case 2:

Another participant aged 67 years from Kapuka village complained that four of her six children died from AIDS related illnesses since 1996. At the age of 67, she has the enormous task of taking care of 5 grandchildren. She says " my sons died, I had to stay with my grandchildren in this poverty, I nurture them, yet I also often fall sick, AIDS took my dear children, I am having a difficult task at hand of educating and feeding my grandchildren."

Looking after young children is a demanding task for this old woman. She explained that she earns a living by doing some part time work on other people's farms during the rainy season and that during the dry season she collects dry grass and bundles it for sale at the price of K1, 000 a piece. The three oldest ones go to school while the two young ones stay at home. The task is really daunting.

The participants were further investigated to get an insight into how many of them were looking after school-going orphaned grandchildren, 75% of the participants reported that they were living with school-going children and that these children were at primary school level and 25% had no school-going children because most of them were either too young or had dropped out of school This means that the orphans benefited from the free primary education policy. This policy partially relieved these elderly women of the school dues burden, but they still complained that it was inadequate. This is because the program provides for tuition but does not cater for other requirements e.g. uniforms, books, and transport money to and from school. Full estimate for a primary school child in Zambia is presented in Table 1.7.

Table 1.7: Educational Requirements for a year in Government Schools

ITEM	GOVERNMENT SCHOOLS
Tuition	K 3,500
PTA Fees	K 1,500
Examination Fees	K 10,000
Uniforms	K 30,000
Books and other Supplies	K 10,000
Shoes	K 30,000
Total	**K 85,000**

Source: 2000 Census of Population and Housing

Annually a parent has to part with K85, 000 for an child in a government day school. For the rural based elderly woman, this cost definitely imposes a very heavy burden on her and the reason why some of the orphans they were taking care of were not in school. The elderly women revealed that some of the children no longer attended school after the death of their parents because of lack of financial resources to pay the school fees. It was revealed that the majority of the school-going children were male orphans and that most of the girls stayed home to help with the household chores such as fetching water and firewood, cleaning the house, cooking and looking after the younger ones. From these results there is a suggestion that the elderly women are finding this task of taking care of orphans left behind after their parents die of AIDS as a major challenge. In this study the grandmothers were the primary carers for these children.

Foster, S. (1993) and Serpell (1996) pointed out that children who grow up without adequate education are less socialized and become less productive members of society. Furthermore, the lack of education will hamper their chances of finding formal sector employment and in a country like Zambia which increasingly requires educated and technically capable people, this lack of human capital will be a national constraint.

The study also indicated that 18% of the male orphans had to look for some odd jobs in order to help support the family, which meant that they had to withdraw from school. This study supports the argument by Barnett and Blackie (1992) that intensive use of child labour increases as a major strategy typically used by the elderly grandmothers. Children may be taken out of school to fill labour and income gaps created when productive adults become ill or are deceased. Whilst the boys were being withdrawn from school to work, some of the girls were withdrawn to help their grandmothers with household chores such as fetching water, cleaning , fetching firewood, cooking and to help look after the younger siblings. In the rural areas educating boys is valued and considered more important than educating girls. The girls are expected to stay at home to help with household chores and encouraged to get married early.

Out of the 20 participants, 5% reported that some of their orphaned grandchildren exhibited HIV/AIDS related symptoms. The elderly women in the study also complained that children denied or deprived of parental guidance and other deprivations were a major problem. The possible explanation for this could be that these women were too old to spend time with children and to raise them in ways that their parents would have. The study also shows that the majority of these elderly women are the main bread winners in multigenerational households, and that the traumatic experience of bringing up a second generation weighs heavily on them.

4.3.5 Impact of HIV/AIDS on Food Consumption

The study shows that 60% of the elderly women's households consume two meals a day. These meals consist of maize meal porridge in the morning and what is called *nshima* with vegetables either, *delele* (ladies fingers), *rape*, *Chibwabwa*, *bondwe* or *cassava leaves* only in the evening. For the 40% of the households that reported eating once a day, they ate at midday *nshima* and vegetables, they had no breakfast and supper. Out of all the participants households none ate three meals a day because they could not afford to. They also reported that before their adult children became ill or died they used to eat three meals a day and the meals consisted of a well balanced diet. They explained that

even though they did not eat meat, chicken, and fish everyday at least they ate beans as a source of protein.

Those who had children that reared some animals even had the opportunity of eating some eggs, meat, and chicken when these animals were slaughtered. 85% of the participants indicated that their meals did not consist of any meat, eggs, chicken, or beans after the illness or death of their adult children because these foodstuffs were unaffordable. In Zambia a study by De Bruyn (1992) found that not only was reducing on consumption of meals common in all rural areas as a coping mechanism, but that it was more common in households with an HIV/AIDS infected adult. For example, 57% of such households had gone entire days without eating in the preceding two months. De Bruyn's findings are different compared to the results of this study because although households reduced on the consumption of meals they did not stay for long periods of time without eating. 15% of the participants reported that the longest period they endured without eating any meals was one day and that it did not happen on a frequent basis.

4.3.6 Sale of Assets

The participants were asked whether they had sold any assets due to the death of their adult child. The findings indicate that 25% of the women sold animals such as chickens and goats in order to buy *mealie meal*, meet funeral costs and pay school fees. 15% of the participants sold both furniture and animals, 10% of the elderly women sold furniture and 50% reported that they did not sell anything because they did not own any furniture and animals. Table 1.8 presents data on the proportion of elderly women that sold assets.

1.8: Presents data on the proportion of participants that sold assets:

Type of asset	Number of elderly women	Percentage
Animals (goats, chickens)	5	25%
Animals and furniture	3	15%
Furniture only	2	10%
Nothing sold	10	50%

From the results presented in table 1.8 above, the most commonly sold items were animals, such as goats and chickens and furniture. The participants indicated that the dominant reasons for selling assets were to buy food, meet funeral costs, and pay school fees. The elderly women reported that the decisions they made to sell assets were not based on the importance or usefulness of the assets to the household but that saving lives was more important than preserving assets. This means that once these elderly women got rid of productive assets, the chances diminish that their households can recover and rebuild their livelihoods. The study revealed that many households sold assets to cover the costs associated with AIDS.

Similar studies were conducted in Bukina Faso and Tanzania by Lwihula (1999) and the findings showed that rural households responded to serious illness and bereavement by selling livestock, and reorganizing household labour.

4.4 The Psychological Effect of HIV/AIDS on the Elderly Women

In-depth interviews with the 20 elderly women also illustrated how emotionally wrenching the experience of caring for an adult child was, and the profound grief that followed the death of their adult child from AIDS. They reported that caring for an HIV/AIDS patient is psychologically challenging. They also complained of experiencing sleepless nights (insomnia), loss of weight and always feeling fatigued. All the elderly women reported that they were worried about what they would feed their granchildren and who would care for them when they, the grandmothers themselves died.

The findings of the study revealed that some of the participants who had lost a number of adult children were left with many grandchildren to take care of, 20% of the elderly women reported that among the orphaned grandchildren they were taking care of they had some grand children who were below the age of 5 years. They complained that they were worried about what to feed these children and that it was difficult to maintain good nutritional practices because of lack of financial resources. The results revealed also that this HIV/AIDS pandemic had psychologically traumatized these elderly women.

4.4.1 Stigma and Discrimination

Data revealed that out of the 20 participants 15% reported that their patients had received psychosocial counseling and that none of the affected members of the family received any psychosocial counseling while caring for the sick patient or after the death of the patient.

The researcher identified that social stigma is a major social, health, and economic challenge. People living with HIV/AIDS and their families are stigmatized and experience discrimination. The participants also indicated that the general attitude of society toward people living with HIV/AIDS was very poor. Some disassociated themselves from people with HIV/AIDS and their families. 65% of the participants complained that they experienced stigma and discrimination. Some of them explained that before their patient's condition progressed to full blown AIDS the neighbours and friends offered help including bathing the patient, but when they realized that this disease was AIDS because the opportunistic infections such as diarrhea, rashes, coughing, loss of weight were persistent, they reduced on their visits and some actually stopped visiting. They also pointed out that shame, fear, and anxiety prevented them from accessing services such as Voluntary Counseling and Testing. Negative attitudes of the health care staff towards the patients with HIV/AIDS and the elderly women also deterred them from attending the clinic. According to these elderly women the health care staff was not compassionate towards them and they were extremely impolite to them and the PLWHA.

They also reported that they were too frightened of the reaction of their neighbours to disclose that their children are sick or died because of AIDS.

4.5 The Effect of HIV/AIDS on the Physical Wellbeing of the Elderly Women

The study also revealed that the older age of the elderly women made them particularly vulnerable to physical strains of care giving. The results show that the main stress related illness suffered by 95% of the participants was frequent headaches. 25% complained of having high blood pressure and of suffering from swelling of the legs, 15% suffered severe backache and 10% of the participant complained of experiencing chest pains and weight loss .The participants were asked if they were on treatment for their various ailments, 30% agreed and 70% reported that they were not on any type of medical treatment, but that they were taking some herbal medicines e.g. roots, bark or leaves prescribed by the traditional healer in their communities. On whether they accessed the health centres or not, 35% answered affirmatively, 50% never accessed the health care centres and 15% said they did access the health care centres sometimes. The data on the distance of the elderly women's villages from the health care centre is presented in Table 1.9 below.

Table 1.9: Data on Distances to the Health Care Centres:

Distance to Health Care Centres	**Number of Elderly Women**	**% N=20**
Near	5	25%
Far (not in close proximity to their homes)	10	50%
Very Far	5	25%

Data shows that 25% of the participants reported that the health care centre was near their villages, 50% complained that it was far and 25% indicated that the health care centre was very far from their areas of residence. All 20 participants reported that their mode of

transport to and from the health care centre was by walking. According to the report by the 20 participants, specific access problems to health care centres they faced included:

a) Distance of the health care centres from their homes, causing them to develop swollen feet from walking.

b) Inadequate medicine for common illnesses at the health care centre.

c) Inability to afford cost of registration and laboratory fees.

d) Shortage of staff, in particular the lack of doctors and trained staff.

e) The negative attitude of health care staff in attending to the needs of elderly women.

f) Inadequate equipment for the treatment of different ailments.

The findings of the study indicated that these elderly women's lives are made up of continuous ill health and high levels of anxiety and stress and that their health has deteriorated under the strain of care giving. Furthermore, that apart from being under financial and economic pressure, older people caring for sick adult children and orphans are also suffering from immense physical and emotional stress resulting from having to deal daily with these new and unfamiliar roles and that there are no structures in the health systems or in the social fabric, to help them manage the stress. Similarly FAO (2001) reported that a study in Zimbabwe found almost two-fifth of older age carers stated that they had experienced physical illness after the death of the adult child under their care.

4.6 Elderly Women's Network for Survival/Coping Mechanisms

The elderly women in the study adopted a variety of mechanisms for coping with the impact of reduced income and loss of labour following an HIV- related long illness or death of an adult child. As already discussed in section 4.3, to cope with a decrease in income, the elderly women indicated that their main source of income was from informal activities such as selling fruits and vegetables, bundles of dry grass, brewing illicit beer and munkoyo, piece work and agricultural activities. They also reported that they reduced consumption of both food and non-food commodities and that the children had to work to generate the income required to meet expenses. The most common extra job cited was

casual agricultural work during the rainy season, planting, weeding, and harvesting on other peoples farms. The results also showed that children assumed adult roles in order to help the grandmother raise money and to meet the household labour demands. 60% of the participants reported that out of the grandchildren they were looking after, the older boys aged between 12 and above helped them by doing some casual work in the farms and piece work by fetching water and firewood for people, and that they had to withdraw the girls aged 8 years and above from school to care for the younger siblings and to help with the domestic chores. 40% of the participants said they only withdrew the girls from school because the boys under their care were too young to look for employment.

4.6.1 Informal Social Support Networks or Traditional Support Structures

The results of the study revealed that 90% of the participants relied on informal social support networks or traditional support structures. These comprised mainly of relatives, friends and neighbours. These were an important resource that the elderly women turned to as part of their coping strategies. Lwiluia (1999) noted that the poor do not live in isolation; there is always some degree of social intercourse among neighbours.

It was observed that the availability and accessibility of informal social support mechanisms was crucial for successful recovery from caring for or the death of an HIV/AIDS infected adult child. In times of stress, the participants reported that they usually resorted to these relationships for help on the basis of trust and reciprocity. Traditionally it is assumed that the extended family, the community at large assists the household socially, economically, psychologically and emotionally. The elderly women in this study were asked to indicate the role played by the extended family and the communities in helping them cope with the income shock during the illness of their adult child. The results show that 85% of the participants had asked for some assistance from relatives, friends and neighbours. The help sought was mainly in the form of food and labour but no assistance with school fees and medical costs. Very few households, 5%, reported not benefiting from informal social support systems. They complained that the help from relatives and friends was not easily obtainable because of inflation, lack of

money, and personal commitments (everyone is being affected by the high morbidity and mortality because of the HIV/AIDS epidemic).

The results of this study show that the old social safety net for orphans, in the form of deep rooted kinship systems and extended networks is finding it hard to cope with the strain of the HIV and AIDS and soaring numbers of orphans in Chongwe Rural.

4.7 The Role of Formal Support Structures in Assisting the Elderly Women in Chongwe Rural e.g. Government, NGOs and the Churches

This section summarizes the findings of the interviews that were conducted with 5 key informants. Key informants included a church leader from the Catholic Diocese, a representative from the Ministry of Community Development and Social Welfare, and three representatives of some of the NGOs that have been operating in Chongwe Rural for more than four years. These are World Vision (WV), Christian Children's Fund (CCF) and Facing the Challenge (FCI). These interviews were conducted in order to assess what these network support structures are doing to mitigate the HIV/AIDS impact on the elderly women in Chongwe Rural.

4.7.1 The Role of the Government in Assisting the Elderly women in Chongwe

The key informant explained that, all issues pertaining to community development and social welfare programs fell under the umbrella of this governing body and that the headquarters was in Lusaka and also that there were District offices in all the Districts in the nine Provinces of Zambia. She reported that the Ministry had structures at community level in all the districts and that it had in place a government social safety program called the Public Welfare Assistance Scheme whose main objective was to contribute towards the alleviation of suffering and improve the quality of life of vulnerable groups. She also explained that this scheme catered for the elderly people, orphans and vulnerable children and that the three components of this scheme were social support, health support and educational support for the orphans and vulnerable children (OVC). She further indicated

that under the social support these vulnerable groups including the elderly people were supported with foodstuff such as a 25kg bag of *mealie meal*, some *kapenta*, dry beans, cooking oil and some salt and that during the farming season they were provided with free maize seed and fertilizer.

She further indicated that under the health support these vulnerable groups were registered under the health exemption policy which stipulated that all children aged 5 years and below and elderly people aged 60 years and above should not pay for any fees at the health care centre, this included registration fees, laboratory fees, consultation fees and medicines.

Under educational support, she explained that the OVC were provided with educational support which included school fees, examination fees, school uniforms, school shoes, books, pens, pencils and any other school requirements. She said that at the District level the structure was called the District Welfare Assistance Committee and at community level it was the Community Welfare Assistance Committee and that the District was linked to the community through the Area Coordinating Committee. She further explained that the members of this committee were NGOs like CCF, WV, Africare, etc, who already had structures in the various zones, meaning they had been operating in those zones for quite a number of years. Since this was a decentralized program the community identified the vulnerable families using a tool called Client Identification Matrix.

When asked whether there was a different selection criteria for the elderly women that were caring for patients, or whose adult child had died from AIDS and those who were taking care of orphans, her response was that all elderly people were treated the same regardless of the fact that some were more vulnerable than others. She also explained that the nutritional support was not monthly; sometimes a family would only receive the food package once or twice a year because according to their policy, their target is 2% of the poorest of the poor and the funding is inadequate and irregular. She also complained that the impact of their programs had not really been felt because the Chongwe Rural

coverage area was too vast and since they only operated through the ACC operating zones, it was difficult for them to reach many people because these ACCs operated in limited zones and not throughout Chongwe District, so most of the zones were left out and did not even know about the assistance that could be availed to them by the Community and Social Welfare department in their district.

The key informant from the Ministry of community development and Social Welfare reported that the Zambian government recognized that an effective response to the HIV/AIDS epidemic required a partnership or multi-sectoral approach, involving government ministries at national and sub-national levels, local and international NGOs, community based organizations, religious organizations, the private sector, the UN and other multinational agencies and bilateral donors. She stressed that the multi-sectoral response required working together to harmonize individual and group efforts into a coordinated response and that each actor or set of actors in the multi-sectoral approach had a place and role to play.

She further explained that the National AIDS Council (NAC) was mandated to provide national and technical leadership for the multi-sectoral response to the HIV/AIDS epidemic. She described the structure at provincial level, the Provincial AIDS Task Force, as a subcommittee of the Provincial Development Coordinating Committee, which coordinated, supervised, and monitored the implementation of HIV/AIDS policies and programmes in the province, and that similarly, the District AIDS Task Force (DATF), as a sub-committee of the District Development Coordinating Committee, which undertook the same functions at the district level. She explained that there were various structures such as Neighbourhood Health Committees, Area Resident Development Committees, and other community based groups which implemented HIV/AIDS programmes at the community and village levels.

The key informant also pointed out that the government in helping to mitigate the HIV/AIDS epidemic recognized the importance of a continuum of care. She explained that this continuum included efforts to prevent HIV infection in the first place, to provide

counseling, spiritual and emotional support and medical care to persons who were HIV-infected or who were living with AIDS, and to sustain those otherwise affected by the epidemic, and to help people living with HIV and AIDS lead secure lives free from discrimination, and to support persons who were otherwise affected by the epidemic. When asked about the availability of VCT services in Chongwe, the results showed that there was a VCT centre at Chongwe District and that people were being encouraged to go for VCT because VCT was an entry point to Antiretroviral Therapy (ART). She explained that people in Chongwe were accessing this service and it had contributed to the reduction of stigma in the community, and that the demand for HIV testing surpassed the current availability of services in Chongwe.

When the key informant was asked about the Antiretroviral Therapy (ART) that were available in Zambia she explained that, the introduction and expanded use of ART in the public health sector in Zambia was one of the most encouraging developments in the fight against HIV/AIDS. She stated that ART could decrease illnesses and improve survival time and that it worked by suppressing HIV replication. Furthermore, the therapy was designed to reduce the viral load (level of virus in the blood) to the lowest possible level (often undetectable) for as long as possible. For almost all users, this slowed down the progression of HIV/AIDS and infected people were able to live healthier and longer lives. She pointed out that this intervention was still relatively new and it was uncertain how long, on average, ART will be able to prolong life and that ART was not a substitute for the treatment of opportunistic infections.

On the issue of ART, the key informant reported that a circular was signed in September 2005 by the Minister of Health announcing that ARVs are free of charge in all the health care centres throughout the country, making them easily accessible to all HIV/AIDS infected people who were already on the ARVs. She explained that although they were accessible they may not be available in some areas because of lack of trained medical staff to administer these types of drugs, and the distances to these health centres. She also pointed out that the obvious and important benefit was that ART delayed disease progression and prolonged life and that in so doing, it reduced the incidence of

opportunistic infections and reduced hospital stays and other health costs associated with HIV-related illnesses.

She further explained that patients using ART were able to return to productive work, which lessened the economic impact of the epidemic and reduced the burden of care from the elderly mothers and contributed to improved productivity and reduced poverty. She said that by prolonging life, ART also reduced the potential number of HIV/AIDS orphans in the community. She also stressed that on its expansion programme the government was scaling up the ART with a target of 100,000 patients on ART by the end of 2005.

The key informant explained that in Chongwe there were twenty four (24) rural health centres, four (4) health posts and one (1) mission hospital situated in Mpanshya and that the district general hospital was under construction. She agreed that the distance to these health care centres from the villages contributed to the elderly women not accessing these centres, including lack of trained medical staff, inadequate equipment for diagnosing illnesses, lack of medicines and the general negative attitudes of the health care staff in dealing with the elderly women's needs.

When the 20 elderly women were asked if they received any assistance from the government, they reported that they did not receive any government support. The main form of public social protection in Zambia are the Social Safety Net Program and the Public Welfare Scheme, these are both supposed to cater for the elderly and orphans and vulnerable children in the whole country. The study shows that 60 % of the participants indicated that they were too old to go through all the application requirements, and 40% of the participants reported that they were not even aware of the existence of these assistance programs. Overall the study participants found public assistance not helpful. The possible explanation for this could be that most of these formal support structures were spread very thinly in Chongwe Rural, this was because they were concentrated in one area considering the fact that the Government projects only operated in areas where the various NGOs had a presence so they operated using the structures that the NGOs had

already put in place. The selection criteria used by the Government to identify likely beneficiaries and to allocate resources for the Public Welfare Assistance scheme was biased in that the common sentiment in rural areas was that everybody was vulnerable. Therefore the project may only target households who were not the neediest, or the selection process may be influenced by local leaders or people with power.

On the issue of ARVs, 15% of the elderly women who were registered under the Catholic Church's home based care programme reported that their patients were taking the drugs and reported that their patient's condition had improved drastically after they begun to take the medication. Their major complaint was lack of food, apparently the medication increases a patient's appetite and besides that, some of the medications have food restrictions and have to be taken before a meal or after a meal. 75% revealed that their patients were not taking any ARVs because they did not have any knowledge about the availability of the drugs or how these drugs work to control HIV/AIDS.

Although the key informant explained that the elderly women aged 60 years and above were exempted from paying user fees under the Zambian Health Policy, all the elderly women in the study cited payment of user fees as one of the reasons why they did not access the health care centres for treatment and they did not have accurate and updated information about the availability of these medical services. This indicated that these women were never sensitized about the availability of free medical services for people in their age-group.

4.7.2 The Role of the Church in Assisting the Elderly Women in Chongwe Rural-Catholic Diocese

According to the Catholic Church representative, the Chongwe Catholic home based care programme has been implemented over a period of four years. At most stages of HIV/AIDS, home-based care, including psychosocial activities, were the most appropriate or practical type of support. She explained that the main aim of home-based

care was to improve the quality of life of clients and to lessen the burden on the family by encouraging and supporting the independence of PLWHA.

Furthermore, the development of HBC models in Zambia was partly in response to the unprecedented costs within the health sector and the pressure on hospital bed occupancy. HBC in Zambia is implemented in two ways:

1) Health institution- initiated outreach programmes that reach out to communities and become integrated into community activities.

2) Community programmes that are often initiated by church-based and other voluntary organizations. These initiatives rely on community volunteers with support from community-based organizations, religious groups, and health facilities.

The objectives of the Chongwe HBC programme have been to create greater awareness of HIV/AIDS among communities, develop home based care and training of human resources. The purpose of this interview was to determine the extent to which the home based concept has been put into practice and to examine the impact of this home based programme on communities. The findings indicated that in terms of its programme achievements, the Chongwe Catholic Diocese had spearheaded the implementation and acceptance of HBC concept by government, NGOs and the communities.

The key informant pointed out that through their programmes, they had managed to make AIDS information and education available to rural communities especially among the young men and women, which had been isolated and not accessed through commonly used media. Significant activity levels were observed in the areas of HBC comprising home visits, patients counseling (psychosocial support), nutritional support consisting of a 25 kg bag of *mealie meal*, a 5 kg bag of dry beans, a 5 kg bag of soya beans, a bar of bathing soap per month and public education concerning HIV/AIDS (targeting the youth in the reproductive aged 15 years to 49 years). The HBC services were provided by community volunteers.

The participants were investigated to find out if they received any support from the churches. Results showed that 50% of the participants who were members of the Catholic Church appreciated the nutritional support of one bag of *mealie meal*, soya beans, one bottle of cooking oil, and one packet of salt that was provided to them by the church per month. 20% of the participants that were members of the United Church of Zambia reported that they also received nutritional support every month which included a 25 kg bag of *mealie meal*, a 5kg bag of *kapenta*, a 5 kg bag of soya and a 5 kg bag of dry beans under the church's home based care program. They also indicated that under this same program the community volunteers helped these elderly people to bath the patient, clean the house and cook. Those who had suffered bereavement reported that the church had provided them with some food during the funeral. They also indicated that under the Home Based Care (HBC) some of the patients received psychosocial counseling. However support from these churches was reported to be limited to church members only, to be inadequate and irregular in that they were supposed to be supplied on a monthly basis but the participants complained that sometimes they would receive this nutritional support after two months. The church going women noted that they valued the care, nutritional support, fellowship, and reassurance they got from the church which increased their will to survive and cope with difficult times. Besides the Home Based Care services the Catholic and United Church of Zambia provided, two of the elderly women from the Baptist church reported that they were given some monetary support by the church towards their children's funeral expenses. These participants who were members of the Catholic Church and United Church of Zambia, 15% said they also received assistance from the NGOs in the form of nutritional and educational support.

4.7.3 The Role of NGOs in Assisting Elderly Women in Chongwe Rural

Key informants from three NGOs operating in Chongwe rural were interviewed with the intention of examining the impact of their programmes on the elderly women and to find out whether these women were involved in any of their programmes and if at all they were benefiting from these projects. The NGOS represented were World Vision (WV), Christian Children's Fund (CCF) and Facing the Challenge (FTC) of HIV/AIDS. Civil

Society included NGOs and these helped to ensure widespread representation of views, interests, and expertise in the fight against HIV/AIDS.

Christian Children's Fund (CCF)

The key informant from CCF explained that the main objective of CCF was to enhance community based care and support for OVC and youth that were infected and affected by HIV/AIDS. He said that their areas of coverage in Chongwe Rural were Mutamino, Chainda, Kapete , Rufunsa, Chimusanya, Chitemelesa , and Mpanshya. He explained that the large number of orphans was one of the most critical social development issues facing Zambia, and that the HIV/AIDS epidemic was the single most important factor contributing to the large number of orphans. He pointed out that CCF Collaborated and shared best practices with government agencies, community based organization, faith based groups and other NGOs to help the overstretched and overburdened extended family cope with care and support for OVC. He said that the activities ranged from providing educational support, creating awareness on HIV/AIDS and STI issues among the youth, promoting and supporting income generating activities. When discussing the orphans living arrangements he explained that CCF had identified the orphan need within the families as:

a) the needs of households in poverty- food, shelter ,bedding and clothing
b) the general needs of children under age 15- health, schooling
c) the needs of children aged 15 and above for access to work

When asked if their project had an impact on the elderly women looking after their children infected with HIV and AIDS and the orphans, he agreed that there were some positive outcomes that they recorded. He further explained that the knowledge base on HIV/AIDS among the youth in the area had increased because of the sensitization campaigns on HIV/AIDS issues. However this awareness creation on HIV/AIDS was not extended to any of the participants of the study, because the main area of focus for the organization was the young men and women of reproductive age. He indicated that the schools in the areas they operated in reported an increase in the number of children

enrolling into schools, the retention rates were high, and the drop-out rates were low because of the educational support they provided for the OVC. Some of the older orphans were trained in income generating activities such as carpentry, tailoring, and poultry rearing and financial support was provided to develop these income generating activities. This he says would in the future help them relieve the burden of income raising from their elderly grandmothers, their livelihoods would improve and they would be able to adopt good nutritional practices in their households.

He explained that the elderly women benefited through the support that was provided for the orphans they were looking after, but they were not included in the awareness raising campaigns, and the trainings in income generating activities. He concluded that support was not provided to the people living with AIDS because of insufficient resources to include people living with HIV and AIDS in their target groups since their main target group were the OVC.

World Vision (WV)

The key informant for World Vision explained that the organization's mission was to reduce the impact of HIV/AIDS on men, women and children in Chongwe by sensitizing and educating them on issues of HIV/AIDS and its related issues, including support for OVC and people living with HIV/AIDS. He also pointed out that the organization's focus was to engage the members of the communities in the development of income generating activities in order to promote economic self sufficiency. He strongly stressed that the impact of their programmes in education and sensitization within the communities had encouraged more people to access the VCT centres for testing in order to find out their HIV status, hence this had led to the reduction of stigma and discrimination in the area.

He described the organizations training programmes in agro-forestry, where the members of the community were taught how to grow nitrogen fixing plants so that they could grow crops without fertilizer, they were also taught about conservation farming and potholing in order for them to be self sustainable. He also said they have encouraged the

community schools to form anti-AIDS clubs for the youth to promote safe sex practices and behavior change among the youth.

On assistance to the vulnerable groups in the communities, he explained that both nutritional support and educational support was provided for the OVC. The nutritional support comprised of a 25 kg bag of *mealie meal*, a 5 kg bag of *kapenta*, and a 5 Kg bag of dry beans, a packet of salt, and a bar of washing soap. He further explained that during the planting season these people were supported with maize seed and fertilizer.

However the findings show that none of the elderly women from the study were actively involved in these programmes. On the impact of these programmes on the elderly women taking care of sick adult children infected with HIV and AIDS and the orphans he explained that, since the elderly women were in the category of the underserved vulnerable groups, they were beneficiaries of the grain-seed and fertilizer scheme. He explained that presently there were no records indicating that some elderly women had been trained in income generating activities and that only the younger women have been receiving training and support in various income generating activities. Furthermore, that they did benefit indirectly from the nutritional support provided for the people living with HIV and AIDS and the orphans. He also complained that the assistance they provided was inadequate because of insufficient funds. He reported that their awareness campaigns attracted the younger men and women of reproductive age and excluded the elderly people. 10% of the elderly women from the study explained that some of the older boys they were taking care of had benefited from the training in income generating activities such as carpentry but had not been supported with initial capital to start the activities.

Facing the Challenge (FTC) of HIV and AIDS

According to the information that was presented by the key informant, FTC is a support group whose members are mostly people living with HIV/AIDS in the community. The objective of this organisation is to encourage involvement and participation in HIV/AIDS activities in the communities. He pointed that these PLWHA members played a leading

role in the process of de-stigmatization of AIDS at community level through HIV/AIDS sensitization programmes for the infected and the affected. He reported that information on HIV/AIDS was disseminated to men, women and children and psychosocial counseling was available for the infected and their affected families'. He explained that they also provided nutritional support for their members and their families on a monthly basis.

When asked if the elderly women were directly involved in their projects, he explained that they were not directly involved because they did not consider them in their targeted category. He said that these elderly women were, however beneficiaries because they consumed some of the food that was given to their patients who were infected with HIV and AIDS under their nutritional support programmes. He explained that although these families received the nutritional supplements it was not enough because of lack of sufficient funds.

The results show that 70% of the participants received assistance from some NGOs operating in the area, 20% from Facing the Challenge of AIDS, 15% from World Vision and 35% from CCF (Christian Children's Fund) and 30% reported that they did not receive any assistance from any formal support structures. These NGOs were reported to support people living with HIV/AIDS with some foodstuff e.g. a 25kg bag of *mealie meal*, 10 kg bag of *kapenta*, a bottle of cooking oil and a packet of salt. The elderly women also mentioned that their orphaned grandchildren were provided with some school requisites and school fees. However the participants complained that this support was inadequate because it did not cover all the children. Considering the primary private formal social support mechanisms, the NGOs (Non governmental organizations) operating in Chongwe Rural are many, the study participants only knew about the ones that have been mentioned in the study.

When asked if they knew about the other NGOs and CBOs (Community Based Organisations) that were operating in the communities the elderly women seemed ignorant about their existence and operations. When asked what they felt could be done

to improve care for persons who were sick with AIDS and for their families, the elderly women recommended that food, medicine, fertiliser, and seed assistance would be required as this would empower the households with a food source for the remainder of the year. 25% of the participants indicated that besides the food, fertliser, and the seed they would really appreciate training in poultry rearing and of course financial support to develop this particular activity. 15% more of the participants were also interested in training in any kind of income generating activity as long as it will bring sustainable income for their households. The results also showed that the majority of the participants, 60%, reported that besides food, fertilizer and seed their major need, were educational support for the orphaned school going grand children that they were looking after.

On the assessment of the role played by the government, NGOs, and the Church in assisting to reduce the impact of HIV and AIDS on the elderly women in Chongwe Rural, the findings of the study revealed that these formal support structures complained about lack of resources considering the magnitude of the disease in the area and the vast geographical area coverage of Chongwe Rural They reported that they wished they could do more for the elderly women but that at the moment their priority targets were the young men and women of reproductive age 15 years to 49 years and the people living with HIV and AIDS. They also explained that their HIV and AIDS awareness campaigns and programmes were designed for this targeted group. They explained that the programmes for educational support for the orphans did record an impact on the elderly women in that their expenditure on school requirements was reduced. From the results of the study it was also found that these formal support systems complained of lack of resources. The government official indicated that there was an impact on the elderly women's household expenditure after the introduction of free primary school education for all children in Zambia in November 2003. The key informants also reported that the nutritional support to the households looking after people living with HIV and AIDS ensured that the patients had access to some food even though the quantity was insufficient and the supply was erratic. From the results of the findings we see that the elderly women benefited indirectly through the programmes for the orphans and the people living with HIV and AIDS, they were taking care of. There were no specific

programmes designed for the well being of these elderly women. The possible explanation for this could be that policy makers were not clear about who the home and community based carer for orphaned children and people living with HIV and AIDS were, what they did and what resources they had, and that these elderly women were excluded from participating in local policy and programme processes of HIV and AIDS, poverty reduction and local planning.

The findings also showed that there was no main focus on addressing the needs of the elderly women as the poorest and most vulnerable. They were merely considered in the general programs addressing any aspect of risk and vulnerability. From the findings of this study, it shows that the older women have shouldered much of the burden of care taking, financial strain, sorrow, and child rearing that have resulted from the AIDS epidemic. That they have done so in relative silence should not condemn them to continued neglect.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

In this chapter, the researcher will discuss the conclusions and recommendations of the study.

5.1 Conclusions and Recommendations

In this study, the researcher had an overall objective of getting an insight into the effects of HIV/AIDS on elderly women in the rural areas, a case study of Chongwe Rural in Zambia. The study attempted to examine the social, economic, psychological, and physical effect of this epidemic on the elderly women. Other objectives included finding out what coping strategies these elderly women were using to reduce the impact of the disease and to assess the role played by the formal support systems (Government, NGOs, and the Church), in assisting these elderly women. The results of this study show that the death or illness of an adult child from HIV/AIDS has an adverse negative effect on elderly women, and that these elderly women are particularly vulnerable to the impact of the disease.

5.1.1 Elderly Women's Knowledge and Perception about HIV/AIDS

The findings of the study indicated that the participants lacked information about the nature of HIV/AIDS, its causes, how it is transmitted, how it can be prevented and its treatment. They believed in the myths and misconceptions of the disease without realizing that these beliefs contributed to stigmatizing the patient. These elderly women were not included in the HIV/AIDS awareness campaign programmes because these programmes only focused on the young men and women of reproductive age, 15 to 49 years. Because of this lack of knowledge about HIV/AIDS the elderly women in their

role as carers of HIV/AIDS did not know how to protect themselves from contracting the disease.

There is need for the elderly women to be targeted with information on HIV/AIDS in order to be part of the nation's effort to halt and reverse the spread of the disease, because elderly women are never included in programmes to disseminate information and control the disease, and there is no international data on HIV/AIDS infection in older women and testing is not carried out on over 49's. Lack of information about HIV/AIDS exposes the elderly women to infection through their role as carers.

5.1.2 Elderly Women's Roles as Carers of HIV/AIDS Patients and Orphaned Grandchildren

The study found that HIV/AIDS has changed the role of elderly women of which the majority in the study 80% was aged between 60-69 years, putting severe pressure on them, and placing multiple burdens upon them. It was also observed that elderly women have become the primary care givers to their children who were infected with HIV/AIDS and their orphaned grandchildren. All the 20 elderly women in the study reported caring for orphaned grandchildren and 30% were currently caring for a sick adult and 70% had recently lost an adult child from HIV/AIDS at the time of the research. This however, has changed their role from being provided for to providing care and support to their sick adult children and grandchildren orphaned by HIV/AIDS.

There is need for policy makers to be clear about whom the home and community based caregivers for orphaned children and PLWHA are, what they do, what resources they have, and provide them with adequate financial, social, and emotional support. There is also need for more research and the data must be disaggregated directed at the elderly women who are providing AIDS-related care.

5.1.3 Elderly Women's Source of Income

The findings of the study revealed that the experience of caring for their sick adult children and their grandchildren orphaned by HIV/AIDS necessitated that the elderly women earn an income, and or work on the land to produce food for the family. The main source of income of these elderly women was from informal activities such as, selling fruits and vegetables, bundles of dry grass which they collected during the dry season, brewing illicit beer and munkoyo, piece work (washing and cleaning other peoples huts), and agricultural activities (planting, weeding, and harvesting). Sometimes they were paid in kind (food) and other times they were paid cash. The study has shown that the illness and death of their adult children had robbed their household of the major sources of support and that the elderly women became the main breadwinners in multigenerational households.

There is need to support these elderly women as assets in the care and support of HIV and AIDS patients and the orphans; through training and financial support in small scale income generating activities. A change in mindset is needed to welcome the elderly women's contributions and participation and take a fresh view of relations between the generations. The elderly women need to be given opportunities to access training in agriculture and credit regardless of age. Policies and programmes have to develop responses to the impact of the epidemic on the development process, bearing in mind the demographic changes which result from AIDS related illnesses and death. For example, traditional agricultural extension programmes train men and women farmers of reproductive age. In the AIDS era, these programmes have to go out of their way to encourage the participation of the elderly women and respond to their needs. This may necessitate the development of new methods of agriculture, as well as new methods of community outreach, by shifting to labour-saving techniques which would enable the elderly women to farm. Schemes to promote their economic security to sustain these new roles must be supported, because poverty is one of the fundamental catalysts in hastening the problems, and actions to redress the situation must target reducing it.

5.1.4 Impact of HIV/AIDS on Food Consumption and Sale of Assets

The results of the study also demonstrated that these elderly women headed households could not sustain their consumption patterns. They were even forced to cut back on consumption of basic food and non-food items. The elderly women in the study faced major problems in finding funds to buy the basic necessities, transport to and from the health care centres, medical costs, food, and school expenses for their grandchildren. This study has also shown that most of these affected households were not able to afford some specific food items, such as meat, eggs, fish, and chicken. The majority, 60% of the elderly women reported that their households including the orphans ate two meals a day. These meals consisted of nshima and vegetables. Another 40% mentioned that they only consumed one meal a day which also consisted mainly of nshima and vegetables. None of these elderly women headed households consumed three meals a day. It was observed in the study that 50% of these elderly women sold assets such as livestock due to the illness and death of their adult children. The dominant reasons for selling these assets were to buy food, meet medical and funeral costs and pay school fees. Thus, the illness and death of an adult child from HIV/AIDS in a household is likely to lead to increased poverty and food insecurity in affected households. Based on the results of this study, one can infer that assets play an important role in managing income shocks related to the illness and death of an adult child from HIV/AIDS and also that the strength of the household in managing the impact of this disease lies in the economic asset base. In the instances where productive assets were sold, such as livestock, it is important to note that such families may be deprived of future ability to sustain production.

There is need for the formal support structures to recognize the heavy burden laid by our society on the elderly women by giving them more subsidies on basic foodstuff and services. The elderly women caring for sick family members must be provided with the basic required materials such as soap, vaseline, disinfectants, disposable gloves food, medication, clothing, blankets, and agricultural inputs such as fertilizer and seeds.

5.1.5 The Effect of HIV/AIDS on the Psychological and Physical Wellbeing of the Elderly Women

The study revealed that the burden of caring for a person with HIV/AIDS was reported as psychologically challenging for the elderly women. All the 20 elderly women in the study complained that they went through a lot of psychological trauma and stress as they saw their children become ill and die. The ones taking care of the orphans also reported that they experienced psychological trauma as they worried about what to feed the children and who would take care of them when they the grandmothers themselves died. According to the findings of the study the general attitude of society towards people living with AIDS and their families was very poor. The elderly women and their families experienced social stigma and discrimination towards the later stage of the disease, when the neighbours and friends found out that the patient was suffering or died from HIV/AIDS. This is because the epidemic, particularly in the rural areas continues to be concealed in stigma, and negative attitudes mainly affect persons with HIV/AIDS and their families because of the myths and misconceptions about the disease. The attitude of health care staff was also reported by the participants to be very negative and contributed to the stigma and discrimination experienced by the PLWHA and the elderly women. The results showed that only15% received psychosocial counseling for their sick patients; however, this service was not extended to any of the members of the family. These women also suffered from stress related physical illnesses due to caring for the sick and death from HIV/AIDS, and fatigue from looking after their orphaned grandchildren. High blood pressure, swollen limbs, chest pains, lower back pains, and severe headaches were cited as the most commonly reported stress related illnesses.

There is need for health care centres to identify and obtain help for the elderly women and the orphans. Special care could include, home visits, psychosocial counselling, and waiving user fees at the health centres. Therefore there is need for the government to review the existing national policies on health and to develop strategies aimed at empowering these old women through improved access to health care services. There is

also need for programmes that are necessary to build and strengthen basic infrastructure especially water and sanitation, to reduce the elderly women's day to day burdens. The health care staff also needs to be sensitized to the effects of AIDS, so they can provide non-stigmatizing care. There is also need to promote the maintenance of older women's physical, psychological wellbeing through the formation of older women's associations.

5.1.6 Elderly Women's Network for Survival/ Coping Mechanisms

The results of the study indicated that the elderly women adopted a variety of mechanisms for coping with the impact of reduced income and loss of labour following an HIV-related long illness or death. In addition to the strategies above, the elderly women withdrew children from school, 60% reported withdrawing older boys aged 12 years and above to help them raise income for food and other expenses, 40% mentioned that they also withdrew girls aged 8 years and above to help with the household chores and take care of their siblings. The girls were at particular risk of being denied an education because they had to stay home to help the grandmother with household chores and look after the siblings. The older boys also assumed adult roles, such as casual work in the farms, fetching water and firewood for some members of the community to help support the family. The major reasons cited for children not attending school was lack of financial resources to pay school fees. The study also revealed that 85% of the participants relied on relatives, friends, and neighbours for moral support and food, but not medical costs and school fees. These traditional support networks could not help much because they too were experiencing similar problems and did not have extra money to help with school fees and medical costs.

One of the Millennium Development Goals is to achieve universal primary education. Thus efforts to put in place policies for universal primary education must be complimented with support to those families who bear the greatest responsibility for orphans. In the elderly women headed households the young girls dropped out of school to assist with domestic chores. The education sector needs to respond to the fact that these orphaned children especially the girls were even less likely than before the HIV and

AIDS epidemic to be able to stay in school long enough to acquire skills for the future. Therefore there is a need for flexible schools, enabling girls to combine doing housework, and looking after siblings with productive activities that can provide skills training as well as conventional education. There is also a need to provide skills training for the older boys aged 12 years and above in courses such as carpentry and bricklaying.

5.1.7 The Role of Formal Support Structures e.g. the Government, NGOs and the Churches in Assisting the Elderly women in Chongwe Rural

The results of the study demonstrated that the assistance provided to the elderly women by the formal support systems such as, the Government, NGOs, and the Church in Chongwe rural was inadequate and irregular. The nutritional support which was provided by the government consisted of a 25kg bag of mealie meal, a bottle of cooking oil, a 5kg bag of kapenta and a 5kg bag of beans. This assistance was only availed to the elderly women only when the supplies were available, depending on the resources that had been allocated for the particular activity. However none of the elderly women from the study benefited from this project because they had no knowledge about the project. The NGOs were supposed to provide per month a 25kg bag of mealie meal, a 10kg bag of kapenta, a packet of salt and World Vision included a 5kg bag of soya. The educational support in the form of tuition, uniforms and books by the NGOs also did not cover all the children and it was insufficient. The majority of the elderly women, 60% complained that they were too old to go through all the application requirements for the Government assistance and 40% of the participants were not even aware of these assistance programmes. The Churches also provided nutritional support on a monthly basis but the participants complained that this support always delayed. This shows that the assistance was too limited and the programs were spread too thinly in Chongwe Rural. Due to poor targeting of the support, the special needs of these elderly women are lost in the general programs that address any aspect of vulnerability.

There is need for wider social protection measures in poverty reduction strategy budgets to target the elderly women in the rural areas affected by HIV and AIDS. Social

protection measures such as child care grants and social welfare schemes would be effective mechanisms to redistribute wealth and target development aid to the elderly women.

Therefore in the Government's, NGO's and Church's fight and mitigation against HIV/AIDS and it's impacts in the rural areas, the elderly women need to be counted, supported, and educated in this task of care and support, in order for them to carry out their role as carers, for their wellbeing, their sick adult children and their orphaned grandchildren. If these elderly women are to benefit from economic development and have a chance of escaping from poverty, they need targeted support, social assistance, and social protection, and political action that confront exclusion. One obvious reason for the neglect of these elderly women is the understandable focus on the orphans they are taking care of. Some of these orphans benefit from the HIV/AIDS awareness campaigns, nutritional support and educational support provided by the NGOs and the Churches although this assistance was reported to be irregular and inadequate. This support is inadequate because it is not enough to cover all the orphaned children in Chongwe Rural and it is irregular because the supply which is supposed to be on a monthly basis is not consistent. Also the greater attention to orphaned children results in part because the vulnerability of children is so apparent. But the neglect of these elderly women has other roots as well, including inadvertent ageism. These elderly women are advanced in age; as such they are invisible and have less public appeal than other age groups, especially the children. The connection between older women and AIDS merits emphasis, not only because of the potential adverse impacts they may suffer and the lack of programs to address these impacts, but also because of the enormous potential they hold for improving the care of persons with HIV/AIDS.

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APPENDIX- A GLOSSARY

Bondwe	A wild plant which is very rich in iron
Chibwabwa	Pumpkin leaves
Delele	Ladies fingers or Okra
Kalembula	Sweet potatoe leaves
Kapenta	Small fish found in rivers and lakes
Mealie Meal	Powdered corn
Munkoyo	Beverage made from fermented corn and wild roots
Nshima	A thick porridge made out of pounded corn

APPENDIX - B

Interview Guide for In-depth Interviews with the Participants:

My name is Molly Sakuringwa-Samakai. I am a Post graduate student from the University of Zambia, School of Humanities and Social Sciences. I am conducting a study on "The Effect of HIV/AIDS on the Elderly Women in Chongwe rural." I would be very grateful if you could give me sincere answers to the questions I shall be asking you, please take your time and be as open as you can be with me. Your responses will be treated with strict confidence.

Yours faithfully

Molly Sakuringwa-Samakai

M.A. Student

APPENDIX-C
INTERVIEW GUIDE FOR THE ELDERLY WOMEN AND THE FORMAL SUPPORT STRUCTURES

Section 1: Background Characteristics of Participants:

1) What is your name?
2) How old were you at your last birthday?
3) How long have you been living in this village?
4) What is your religion?
5) Are you married, single, divorced, or widowed?
6) How many children do you have? How many males and how many females?
7) Do you live with any of your sons/daughters?
8) How many years have you lived with her/him?

Section 2: Education and HIV/AIDS Perception

1) Have you ever attended school? if so what is the highest grade level of school you attended- primary, secondary, or higher
2) What do you know about the disease AIDS e.g. how is it transmitted from one person to another?
3) Is there anything a person can do to avoid getting AIDS?
4) How common is HIV/AIDS in your community
5) If it has increased why has it increased?
6) Where does a person in this community go for help when he or she becomes sick with AIDS?
7) Has any of your adult sons/daughter of you household been very sick from AIDS e.g. unable to do normal things for 3 to 12 months
8) If still sick are you the one caring for her/him and if dead are you the one who was caring for him/her?
9) Did anybody outside your family household help you in caring for the sick patient?

10) Have any of your adult children sons/daughters that were sick with AIDS and that you cared for die from AIDS?

Section 3: Socio- Economic Characteristics of the Participant:

1) Was the sick patient working or running a business?
2) Was the deceased person working or running a business?
3) If working how much support did she /he provide for you?
4) Did the deceased have any children, how many males and how many females?
5) Who is caring for these children? If they are too young who fetches water and firewood for them? How far are these water and energy sources?
6) Are these children school going?
7) What is your main source of income?
8) Are any of the children working to help you in the home or outside the home? How old are these children?
9) What is the total amount of money you use to educate them?
10) How many meals do members of your household eat per day?
11) Do the meals consist of any meat or children?
12) Have you cut down on any expenditure since the illness or the death?
13) How much money do you spend per month on basic necessities, food, medicine and, health scheme.
14) Is the patient on Anti-Retroviral therapy if yes do you buy the drugs?
15) Did you have to sell any assets to buy basic necessities?
16) Was any assistance available from relatives, friends, organistion or, government during the illness or after the death?
17) What sort of assistance was provided and was it enough?

Section 4: Psychological Characteristics of the Participant:

1) How does the illness of your son/ daughter affect you emotionally?
2) How did the death of your son/daughter affect you emotionally?

3) Did your friends and relatives give you emotional support during the illness?
4) Did your friends and relatives give you emotional support when your son /daughter died and afterwards?
5) Did any organization provide you or the patient with psycho-social counseling during the illness?
6) Did any organization provide you or the orphans with psycho-social counseling after the patient died?
7) Are you or the orphans discriminated or stigmatized by the people in your community?

Section 5: Physical Characteristics of the Participant:

1) Do you suffer from any diseases that are stress related such as high blood pressure?
2) Are you on treatment for this disease?
3) Do you go to the health care centre?
4) How far is the health care centre from your village?
5) How do you get to the health centre?

Section 6: Networks for Survival :

1) Where does a person in your community go for help when he /she become sick with AIDS?
2) Which organizations or individuals in this community usually provides help to people with AIDS/
3) What type of help do they give?
4) How helpful is this assistance?
5) What can be done to improve care for persons who are sick with AIDS and for their families?
6) Do you think that good services are provided at the health care centre?

Coping Strategies:

1) What kind of work do you do?
2) Are you paid for this work and how?
3) Do any of the orphans you are taking care of working?

Interview Guide for Government Officials, Church Leaders , and NGO Representatives

1) What sort of assistance do you provide your members and their families during illness and at time of death and after death?
2) Has the church done anything specifically to prevent the spread of HIV/AIDS in the community?
3) What has been the impact of your programs?
4) Is there an AIDS committee in this community? How active is it?
5) In this community how active are the traditional healers in AIDS prevention?
6) Do you have VCT centres in this area? How accessible are they?
7) Are ARVs readily available at the health centres? Is education about AIDS provided in the churches and all the schools?
8) How satisfied are people in this community with the health care staff in this area?
9) How common is AIDS in this area?
10) Are elderly women involved in most of your development programmes than elderly men?
11) Do the elderly women in your community benefit from your projects?