

**THE PSYCHOSOCIAL IMPACT ON RURAL GRANDMOTHERS  
CARING FOR THEIR GRANDCHILDREN ORPHANED BY HIV/AIDS**

by

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**DECLARATION**

I declare that: **The psychosocial impact on rural grandmothers caring for their grandchildren orphaned by HIV/AIDS**, is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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Date

**SUMMARY****THE PSYCHOSOCIAL IMPACT ON RURAL GRANDMOTHERS CARING FOR THEIR GRANDCHILDREN ORPHANED BY HIV/AIDS**

This exploratory study investigated the psychosocial impact on rural grandmothers of Gutu, Zimbabwe, caring for their grandchildren orphaned by HIV/AIDS. The participants included 12 paternal and maternal grandmother-caregivers from four districts of Gutu, whose ages ranged from 56 to 76 years with orphans in their care ranging from infants to 18 years. The present study made use of Erikson's psychosocial theory of development on late adulthood. Data were gathered using semi-structured open-ended interviews in the participants' homes. Interpretive analysis was used to analyse the audio-taped data. Findings reveal that most grandmothers are experiencing a personal toll in dealing with the late adult crisis of integrity versus despair, including finding it difficult to resolve the grief of losing children while engaging in full time grandparenting in a stigmatising society. Participants reported a need for support and interventions tailored to their unique needs. Counselling, social support, financial assistance, and skills and knowledge about HIV/AIDS are therefore recommended.

**KEYWORDS:**

Caregivers; epidemic; HIV/AIDS; grandmother-caregivers; grandparenting; grandparents; orphaned grandchildren; psychosocial impact; rural

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## **CHAPTER 1**

### **INTRODUCTION**

#### **1.1 OVERVIEW OF THE PROBLEM**

The AIDS epidemic is creating a generation of orphans, with parents being wiped out in the prime of their life. According to UNAIDS (2004), AIDS is unique in human history in its spread, its extent, and the depth of its impact. Since the first AIDS case was diagnosed in 1981, the world has struggled to come to grips with its extraordinary dimensions. Early efforts to mount an effective response were fragmented, piecemeal, and vastly under resourced (UNAIDS, 2004). However, AIDS still expands relentlessly, destroying people's lives and, in many cases, seriously damaging the fabric of societies. It is leaving behind vulnerable age groups, the very old and the very young, the former turning into parents again, despite the feebleness of their bodies. Observations show that most infected partners die in succession; that is, when a husband dies of AIDS, the wife is also often living with AIDS and dies shortly thereafter, leaving children as orphans, and, thereby, creating a parenting crisis in most societies, including that of Zimbabwe.

#### **1.2 AIDS IN AFRICA**

Sub-Saharan Africa contains just over 10 percent of the world's population but is home to close to two-thirds of all people living with HIV (housing 25 million of them). In 2003 alone, an estimated 3 million people became infected in the region while 2.2 million died of AIDS (UNAIDS, 2004). The worst orphan crisis is in sub-Saharan Africa, where 12 million children have lost one or both parents to AIDS (UNAIDS, 2005). By 2010, this number is expected to climb to more than 18 million, as estimated by UNAIDS. On the other hand, according to UNICEF (2003), owing to HIV/AIDS, the number of orphans in sub-Saharan Africa with no living parents is predicted to nearly triple by 2010. Thus the large number of deaths in the productive age groups, attributable to AIDS, has serious consequences for the economic and social development of the continent.

According to UNICEF (2003) Southern Africa is the most severely affected, with more than 16 percent of its adult population being HIV positive. However, average levels of prevalence are lower in East Africa (6 percent) and West and Central Africa (4.5 percent) and much lower in North Africa (under 0.1 percent). Yet still the epidemic has grown. Faced with a disease that is both deadly and hard to control, many have preferred to deny its existence and to stigmatise those who have the infection. These attitudes, combined with a lack of access to treatment services, help explain why an estimated 95 percent of men and women across Africa do not know their HIV status (UNICEF, 2003). This only worsens the situation and aggravates the crisis facing Africa as a continent because AIDS continues to ravage societies, leaving behind weakened societies and changed parental patterns. According to UNAIDS (2006), data indicate that the HIV incidence rate has peaked in most countries. However, the epidemic is highly diverse and especially severe in Southern Africa, where some of the epidemic is still expanding. Sub-Saharan Africa therefore remains the worst-affected region in the world. Southern Africa, on the other hand, remains the global epicentre of the epidemic with almost one in three people infected with HIV in this sub region (UNAIDS, 2006).

### **1.2.1 AIDS in Zimbabwe**

Zimbabwe has been confronted by four major challenges in recent years; increasing poverty, the AIDS epidemic, a polarised political environment, and serious droughts (UNICEF, 2003). The first known case of AIDS in Zimbabwe was identified in 1985, and, since then, the problem of HIV/AIDS has continued to grow at an alarming rate. The AIDS epidemic has resulted in an estimated 33.7 percent infection rate amongst adults and a 12 percent infection rate amongst children. By the end of 2001, Zimbabwe's adult HIV prevalence was the third highest in the world, following that of Botswana (38.8 percent) and Swaziland (34.5 percent) (UNICEF, 2003). Of note is that, in 2002, UNAIDS estimated that 34 percent of Zimbabwe's sexually active population was HIV positive (Himerfalb, 2003). The weakened society of Zimbabwe is now faced with another challenge; that of vulnerable children whose parents die of AIDS. These children find themselves in the care of grandmothers who are mostly situated in rural areas, as the

nature of their parents' illness forces these parents to spend their last days in the home-based care of their mothers.

HIV/AIDS continues to infect large numbers of Zimbabweans. Analysis indicates that 24.6 percent of the entire adult population (ages 15 – 49) is currently infected, making Zimbabwe one of the most seriously affected countries in the world. What worsens matters, is that the majority of Zimbabweans who are infected do not even know their HIV status (National AIDS Council, NAC, 2004). At the end of 2001, UNAIDS estimated that 2.3 million Zimbabweans were living with HIV/AIDS; of them, 2 million were adults (ages 15 – 49). However, there have been some new notable trends showing declines in national HIV prevalence in Zimbabwe (UNAIDS, 2006). Data from national sentinel surveillance, and national and local community based surveys, show a declining trend in HIV prevalence (UNAIDS, 2006). For example, national adult HIV prevalence is estimated at 20.1 percent down from 22.1 percent, while HIV prevalence among pregnant women attending antenatal clinics fell from 32 percent to 24 percent. According to UNAIDS (2006), this has been attributable to many women and men delaying their sexual debut and avoiding sexual liaisons. Nationally, there appears to have been a substantial increase in condom use since the early 1990s. Such behavioural change is likely to be associated with a combination of AIDS awareness, relatively extensive health infrastructure, and a growing fear of AIDS mortality. However, a significant part of the decline in HIV prevalence is attributable to high mortality rates. With 1.7 million people living with HIV, Zimbabwe needs to sustain the declining trend in HIV prevalence and dramatically improve the provision of antiretroviral treatment if it is to gradually bring its epidemic under control. Notably, an estimated 320 000 people needed antiretroviral treatment in 2005, yet about 23 000 were receiving antiretroviral drugs (UNAIDS, 2006).

### **1.2.2 Increase in number of orphans**

One of the most serious consequences of the HIV/AIDS epidemic is the rapid increase in the number of orphans. The greatest orphan crisis is in sub-Saharan Africa where 12 million children have lost one or both parents to AIDS. By 2010, this number is expected

to climb to more than 18 million (UNAIDS, 2004). The total number of orphans has risen dramatically in the country, largely as a consequence of the epidemic. The number of orphans rose from 345 000 in 1998 to 1.14 million in 2003, and is expected to stay near that level till 2018 (NAC, 2004). As staggering as these numbers are, the crisis will worsen if parents struck by HIV do not obtain access to life-prolonging treatment and effective prevention services. The question, however, is, how many people can afford such measures in a country like Zimbabwe where inflation is continuously rising?

Globally, only half of countries have a policy to address the needs of children orphaned or made vulnerable by the epidemic (UNAIDS, 2006). In sub-Saharan Africa, of the 25 out of 29 countries reportedly having national policies in place to address the additional HIV/AIDS-related needs of orphans and other vulnerable children, only ten countries have effective policies, yet the needs of such children are most pressing (UNAIDS, 2006). Nevertheless, children orphaned by AIDS lag behind non-orphans in rates of school attendance, with 62 percent of children orphaned by AIDS in Africa attending school in 2005, compared to 70 percent of non-orphans (UNICEF, 2005). Globally, UNAIDS estimates that less than 10 percent of children orphaned or made vulnerable by AIDS are receiving external support of any kind. No matter how the AIDS epidemic takes shape in any given country, its social and economic effects, and particularly its erosion of human capital will continue to grow for many years after prevalence begin to fall.

Zimbabwe records an orphan rate of 17.6 percent with more than three-quarters being orphaned due to AIDS. This number is estimated to rise to 21 percent or 1.2 million, with 89 percent of these children becoming orphans because of the epidemic. Life expectancy is projected to decrease to 35 years or even lower by 2010 (UNICEF, 2003). The death toll from AIDS has been high and continues to rise. In 2003, more than 485 Zimbabweans of all ages were dying every single day of the year because HIV had destroyed the ability of their immune system to resist opportunistic infections (NAC, 2004). The large number of deaths in the productive age group attributable to AIDS is having serious effects on the social fabric of society. Notable is the high mortality in

these ages, which results in large numbers of orphaned children with no one to take care of them except aging grandparents. Owing to the pressures mounting on the extended family, elderly women are called upon to nurture the growing number of orphaned children, the majority of whom are survivors of AIDS-affected households.

### **1.3 CULTURAL BACKGROUND**

Most rural Zimbabweans live traditional lives, with the majority being the elderly who identify with their rural homes as well as their traditional values. Before the AIDS epidemic, orphans as a group deserving special attention were virtually unknown to the Zimbabwean population. If a man (father) died, his brothers and male cousins took over the responsibility for the surviving wife and children and this did not always involve marriage. In fact, when the time came for the surviving wife (mother) to pick out her 'replacement husband' during rituals, she could pick one of her own sons or her late husband's sister to indicate that she was not really interested in cohabiting with any other male member of her late husband's family (UNICEF, 1998).

On the other hand, in the event that a woman (mother) died, the surviving husband was sometimes given a 'replacement wife' by his late wife's family, or he remarried in order that the children might have a mother figure in their lives. The extended family was still intact at that stage, as the children could alternatively be taken by an aunt (mother's or father's sister), or other relative. Thus in both cases, the children's welfare was assured. Rarely were children of a tender age handed into the permanent care of elderly grandparents who in many cases needed care themselves (UNICEF, 1998).

#### **1.3.1 Family support systems**

In most African societies, the past, a sense of duty and responsibility of extended families towards other members was almost without limits. Even though a family did not possess sufficient resources to care for existing family members, orphaned children were taken in. This was the basis for the assertion that traditionally, 'there was no such thing as an



orphan in Africa' (Foster, 2000, p. 56). Traditional life was characterised by brotherhood, with a sense of belonging to a large family and in groups, rather than individuals. The extended family was there to provide support and the members used to share many assets. They lived as a collective community, as opposed to individualism, hence they could accommodate orphans.

Foster (2000) further asserts that the art of marriage was not so much the linking together of two individuals from two families. Rather, when marriage was decided upon, a bride price in the form of a number of cattle was paid to the bride's family; which entailed that the payment of bride price led to future children becoming the responsibility not only of the father but of his family as well. Therefore, traditionally, the concept of a 'social' orphan did not exist in Zimbabwean societies (Foster, 2000). This meant that orphaned children were cared for by members of their extended family, especially by paternal aunts and uncles who took on the caregiving functions of parents. This further emphasises that the extended family functioned as the traditional social security system and its members were responsible for the protection of the vulnerable, the care of the poor and sick, and the transmission of traditional social values and education (Foster, 2000). Grandparents would, therefore, rarely be recruited into childcare on a full time basis, but, rather, old age was regarded as a blessing, deserving honour, respect, and sympathy. Traditionally, the elderly are supposed to be cared for, as explained by the Shona idiom '*chirere mangwana chigokurerawo*' [You rear your child to be reared in return in the future].

According to Bourdillon (1998), in writing about the Shona people, one practical result of the extended family system was that, should the father of a family be away from home for some time, or should he die, one of his brothers or even a paternal cousin could take his place, assuming legal and economic responsibility for his children. Consequently, the large extended families of the Shona people helped them to care for orphans and widows, and also for the elderly and disabled, the burden of caring for whom being shared between a large group of close relatives. The unfortunate irony, however, is that the once cared for elderly are now caregivers themselves as a result of the AIDS epidemic.

### **1.3.2 Gender and society**

Gender refers to the socially determined personal and psychological characteristics associated with being male or female, namely masculinity and femininity (Zimbabwe National HIV/AIDS Policy, 1999). In this respect, another contribution to the increase in the spread of AIDS among the Shona people lies in their culture, which, according to Bourdillon (1998), favours males. Bourdillon (1998) asserts that marital fidelity on the part of the husband is not essential to Shona marriage, but, that the husband is supposed to keep his wife informed of his extra-marital relations, and failure to do this may be regarded as endangering his children. This is further supported by the Shona idiom which says that, 'a man is a bull'. As a result, men's masculinity enables them to acquire more 'scars,' since a bull is marked by its scars, which may include extra-marital affairs without being questioned by society. AIDS impacts on women by increasing their care load in the home and leaving many women infected and widowed. Their economic hardships are worsened because traditional structural support systems do not favour them. Their husbands may infect them, while most in-laws send the wife back to her 'people' when she falls ill. She often leaves with her children. Subsequently, grandmothers may be recruited into caring for an ailing adult daughter, facing a slow and agonising death, as well as for the grandchildren.

Women in rural areas face competing demands with respect to crop production and care for family members suffering from AIDS-related illnesses. Traditionally, the burden of care for sick family members has always been reserved for women, who usually lack the resources and training to provide adequate home-based care. In the present case, rural grandmothers increasingly face competing demands to fetch food, to offer care for ailing children suffering from opportunistic infections, to provide care and consolation to bereaved grandchildren, while protecting their own health.

## **1.4 STATEMENT OF THE PROBLEM**

The AIDS epidemic has affected every aspect of life in Africa, from people's livelihoods to the capacities of societies. Caregiving patterns have not been spared by the epidemic but rather are the worst hit as rural grandmothers face new challenges of grandparenting. One should note that grandmothers have always been available to take on the role of surrogate mothers when parents migrated to the urban areas or as regards children whose parents were divorced or separated. However, this was often temporary and stemmed from individual willingness, unlike the present era of AIDS where grandmothers are often left with no other alternative.

The goal of this study was therefore to explore the psychosocial impact on rural grandmothers caring for their grandchildren orphaned by HIV/AIDS. The qualitative study attempted to contribute to the current knowledge base regarding grandparents and the role of grandparenting, by exploring the topic in relation to grandmothers in a specific rural setting. The main focus of the study was to investigate the experiences of giving care to orphaned grandchildren in a stigmatising and discriminating society, especially on these households affected by AIDS through association. The study's theoretical development is derived from the gerontological concept of Erikson's theory (1982) of psychosocial development in late adulthood.

### **1.4.1 The extended family**

A number of factors contribute to the weakening of the extended family, which include: labour migration, the cash economy, demographic changes, formal education, and urbanisation. As a result, these have led to a reduction in the frequency of contact with relatives and encouraged social and economic dependence; possessions are perceived as personal property and no longer belong to the extended family (Foster, 2000). However, the need to provide care and support for the large number of orphans is placing considerable strain on the extended family. Although, according to Foster (2000), the extended family is not a social sponge with an infinite capacity to soak up orphans. This

may as well be due to the over-stretched household resources and the discouraging number of deaths from HIV/AIDS.

#### **1.4.2 Present day marriages**

In recent years, the custom of the bride price is still commonly practised, though this often consists of a cash payment earned by the husband-to-be rather than cattle and other possessions provided by members of his extended family. Marriage itself has become more a contract between two individuals, leading to weaker linkages between and within extended families. As a result, children are no longer the collective responsibility of communities, which, according to Foster (2000), inevitably leads to a crisis when illness and death strike a family. Grandparents, usually grandmothers, become the only recipients of the burdens, as they feel obliged to care for the children and grandchildren, even under difficult circumstances.

The current urban lifestyle and tendency to emulate the western nuclear family also play a role in eroding the concept of an extended family support system in Zimbabwe. Noteworthy as well, is that even funeral rituals and expenses, which were once an affair of the whole community, are becoming a household burden. Therefore, as AIDS continues to wipe out economically active citizens, households are left impoverished and in vulnerable situations (Foster, 2000).

Another causal factor contributing to the increase in grandmother led households in most Zimbabwean communities, as noted by Foster (2000), is the imposing of a bride price with high monetary value. This has led to unions frequently being established without the payment of this price. Unrecognised by relatives from either family, such unions are inherently less stable and children from such unions may be deemed to belong to neither extended family. This is usually common among young women who may form more than one such union, and if these fail, these women tend to leave their children with their mothers and will only return home when they themselves fall ill and eventually die, leaving most grandmothers with the burden of childcare.

### **1.4.3 Traditional safety net versus alternative safety net**

Owing to such dynamics in society as discussed above, some traditional roles of the extended family have been modified whilst others have almost disappeared. Traditionally, the safety net for orphans consisted of (paternal) aunts and uncles, while the grandparents constituted the alternative safety net. Nowadays, the alternative net has become the most functional safety net. Hence, as the number of orphaned children in a community increases and uncles and aunts, the traditional first choice as substitute caregivers, become unavailable, grandparents are recruited into childcare (Foster, 2000). Consequently, a new group of parents is emerging.

Grandparents are often a last resort as caregivers and agree to take orphans because other relatives refuse to take on the responsibility (Mckerrow, 1997, cited in Foster, 2000). Therefore, grandparents, usually grandmothers, are increasingly becoming the care recipients of orphaned grandchildren, since other surviving relatives may refuse to add orphans to their households, given the harsh economic conditions in Zimbabwe. In the light of this thinking, existing members of the extended family may not feel obliged to welcome orphans when they are not sure of the future of their own children. As AIDS continues to kill their sons and daughters, grandmothers are caught in a situation where they need to care for the well-being of their ill children as well as bereaved grandchildren. One should note that these grandmothers may be at risk as regards their own health and social losses (Poindexter & Linsk, 1998).

In community after community, elderly women became the economic and emotional safety net for grandchildren orphaned by AIDS. While the extended family structure has been the most effective community response to the AIDS crisis, in terms of orphans, very rarely are their needs addressed by AIDS programmes (UNAIDS, 2005).

#### **1.4.4 Grandmothers becoming mothers again**

The HIV/AIDS epidemic is leaving in its wake an increasing number of orphans and severely eroded and weakened households. Those affected indirectly are the most vulnerable: grandmothers and orphans. They are left to cope often without their main source of financial support, since an AIDS illness may deplete all available resources. In the wake of acute food shortages, the traditional African coping mechanisms during periods of hunger (for example *zunde ramambo*) no longer function when productive members of society are either dying or too ill to be resilient and to provide support.

According to UNICEF (2003), the death of a mother is more critical for children below the age of five, while the death of a father has a greater effect on the development opportunities of older children. However, a child losing both parents is generally the most vulnerable of all orphans. Yet, a mixture of such children is often found in most grandmother-led households. While these grandmothers go through the traumatic hardships of the psychological impact of the illness, death, and other changes in the family structure, they need to acquire practical skills and resources to care for their grandchildren. Therefore, in addition to mourning the loss of children to a stigmatised illness and death, these women are faced with the challenges of caring for their grandchildren (Winston, 2006).

Caregiving for an ill adult, who inevitably faces death in the not-too distant future, can be an extremely trying and difficult experience for most elderly grandmothers, especially coupled with the responsibility of full time orphan care. According to UNICEF (2003), around 30 to 40 percent of caregivers in rural communities of Zimbabwe are grandparents, usually with more than one grandchild to care for. It is therefore evident that there are a growing number of grandmothers and even great grandmothers taking on this responsibility.

The present qualitative study, therefore, seeks to investigate how rural grandmothers experience and cope with the loss of an adult child or children to an AIDS death while

parenting orphaned grandchildren. Very little is known about how these women grieve their several losses as they assume the 'off-time' role of parenting to a generation of children without parents. Scant attention has also been paid to how these grandmothers cope with and facilitate the grieving process for their orphaned grandchildren. Their role in this respect deserves exploration as AIDS continues to kill their children, leading to an increase in the number of orphans. The quest of the study, therefore, was the psychosocial impact on rural grandmothers caring for their grandchildren orphaned by HIV/AIDS in Zimbabwe

## **1.5 CHAPTER SUMMARY**

The chapter provided an overview of the problem of HIV/AIDS in Zimbabwe and on the continent at large. Factors leading to grandparents becoming caregivers to orphaned grandchildren have been highlighted. The next chapter presents a review of the literature relevant to the study.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

It is now commonplace that grandmothers are the caregivers for orphans. The grandmothers are impoverished, their days numbered and the decimation of families is so complete that there is often no one left in the generation coming up behind. (Fredriksson & Kanabus, 2005, p. 7)

In the above quotation, Fredriksson and Kanabus (2005) have quoted the September 2003 speech of Stephen Lewis, the then UN Secretary-General's special envoy for HIV/AIDS in Africa. According to Kimmel (1990), in citing Erikson's psychosocial development theory, the final stage in adulthood is accompanied by a growing awareness of the finitude of life and of one's closeness to death. The critical task during this stage is to evaluate one's life accomplishments. A resulting sense of integrity reflects an affirmation that one's life has been a meaningful adventure in history. Its opposite is a sense of despair, which is an existential sense of meaninglessness and a feeling that one's life was wasted or should have been different from what it was (Kimmel, 1990). Erikson (1982) therefore discusses a framework where one would look back over one's life and deal with the question of the meaningless of one's life, the intersection of one's life with history, and the degree to which one's life was a worthwhile venture. Based on Erikson's theoretical framework as regards to late adulthood, this chapter explores available literature in relation to caregiving at an old age and the challenges which grandparents face.

#### **2.2 GRANDPARENTHOOD**

According to Erikson (1982), old age should be an averagely expectable experience to be anticipated by means of planning. It should provide a meaningful interplay between one's



beginning and end as well as some finite sense of summary and, possibly, a more active anticipation of dying. Neugarten and Weinstein (1964) propose five distinctive types of grandparenting styles. However, these mostly provide a detailed analysis of the United States (US) as opposed to the African scenario. The first of these parenting styles is the formal type (who provides special treats and presents for the children and often baby-sit), second, the fun-seeker type (who plays a consultancy role), third, the distant figure type (often remote in terms of physical contact and distance), fourth, the reservoir of family wisdom type (characterised by grandparents who provide special skills, resources, and knowledge to young members of the family structure), while the final type is the surrogate, which is the main focus of this study, and refers to grandparents who are often the caregivers of the children. The surrogate type is quite common today due to the increasing number of single parent families and families where both parents work outside the home. However, in the Zimbabwean scenario and in other parts of sub-Saharan Africa, this is mainly due to the scourge of HIV/AIDS.

Historically, grandparents have often cared for grandchildren when parents were no longer present. According to Myers, Kropf, and Robinson (2002), the pattern today, however, suggests an increase in the number of dysfunctional parents who remain in the picture but are unable or unwilling to nurture their own children. While, after crack-cocaine addiction and incarceration, this is considered as the third most common reason that grandchildren live with their grandparents in the US (Myers et al., 2002), in most African societies, grandparents care for their grandchildren because their own children died of HIV/AIDS.

Older people are viewed as sources of wisdom, which is associated with their grey hair. In most African societies, grandparenting has always been a common phenomenon but this was not often on a full time basis. In an account of adult development, Smolak (1993) found that the actual decision that makes grandparents full time caregivers is out of their control. In the present scenario of the HIV/AIDS epidemic, most grandmothers find themselves with no option but to care for their orphaned grandchildren.

According to Smolak (1993), grandparenthood is evidence of the resilience and persistence of people. Thus their presence gives the family a sense of continuity, rootedness, and perhaps the ability to survive adversity. Notably, this role of grandparenting is more likely to be assumed by women since they have always been accorded this role in most societies, and because they often outlive men. However, grandmothers can view this sense of continuity differently, as they may question why their lives are being spared when their offspring are taken in the prime of their lives (Cook & Oltjenbruns, 1989).

According to Smith (1991), in writing about Italian older caregivers, maternal grandmothers stated that they had always been very close to their daughters and grandchildren, and had taken an active part in the care of the children right from birth, when they substituted for the mother. They declared that they found the situation gratifying. On the contrary, paternal grandmothers referred to a greater detachment and let it be understood that this was because of the presence of maternal grandmothers, whom they possibly saw as a rival. Therefore it seems that grandparenting can be affected by the nature of the relationship between the in-laws.

In black and Latin families, grandparents often occupy a central position in the family network, particularly for children living in chaotic and unstable conditions (Brownell, Berman, Nelson, & Fofana, 2003). Brownell et al. (2003) found that, in the above mentioned societies, substance abusing parents, teen mothers, parents who have been incarcerated, and those with chronic physical or mental illnesses usually depended on grandmothers as substitute caregivers.

Orb and Davey (2005) reported that it is important to acknowledge that most grandparents enjoy the company of their grandchildren. However, several studies have indicated that grandparents experience difficulties and concerns in parenting these children, in particular those grandparents who take the primary responsibility of being a parent. In addition, Orb and Davey (2005) found that full time grandmothers claim less life satisfaction than those grandmothers who provide part time care, thus resonating with

Erikson's psychosocial development theory regarding late adulthood, whereby these grandmothers possibly live in despair. Erikson (1982) argued that much of the elderly's despair is, in fact, a continuing sense of stagnation.

Surrogate parenting or full-time grandparenting has been a pattern for African American grandparents in the US society (Jackson, 1986). Jackson's work is consistent with that of Cox (2002), who claimed that it has been a common practice for black grandmothers to accept and raise their grandchildren as well as their more extended kin and even other orphans. However, Cox (2002) cautioned that the practice of surrogate parenting should not be perceived as expected or desired among today's grandparents, for many, it means that other options must be foregone as they assume the new roles and responsibilities.

### **2.3 GRANDMOTHERS' POSITION AS CAREGIVERS**

In the past, children were frequently cared for by their grandparents because their parents worked elsewhere, and in certain cultures, children born out of wedlock were customarily left with the maternal grandmother. The grandparents nevertheless still retained contact with their children, but as Karim and Karim (2005) stated, in the skipped generation family unit of the HIV/AIDS epidemic, this contact has disappeared.

In Safman's (2004) view, grandmothers are described as the most appropriate caregivers for children whose parents had died or were unable to provide care. Grandmothers are also described as being experienced in raising children and are believed to share in equal measure the parents' interest in and affection for children. Also, they are seen to have fewer obligations to compete with childrearing as they are described as being at home and available to provide childcare. Winston (2006) disputed this, arguing that the role of grandparenting is not always freely chosen but is adopted because of familial expectations and cultural norms. Winston (2006) further argued that many grandmothers who assume the surrogate-parenting role for their grandchildren often do so under compulsion. Erikson (1982) postulated that old age should be an averagely expectable experience to be anticipated by means of planning.

### 2.3.1 Cultural expectations

Citing the role played by culture in childrearing, Strokes and Greenstone (1981) claimed that foster care placement or adoption outside the extended family violates the values of many African American families and is rather sought as an alternative when all other options are exhausted. Hence, this leaves most grandparents with little or no option but to take in their orphaned grandchildren, often under difficult circumstances. Orb and Davey (2005) found that most grandmothers reported that they were unprepared for the parenting role and for most of these grandmothers, the most compelling reason for taking on this new and unexpected role was the welfare of the children. One should note that the unexpected role may arrive when some grandmothers will be grieving the loss of a loved one, or even facing menopausal changes.

Pinpointing the influence of culture on childrearing patterns, Winston (2003) in investigating African American grandmothers parenting AIDS orphans, argues that even in households where there are two grandparents, the grandmother usually assumes the caregiving duties. This seems to be consistent with lifelong gender and socio-cultural role expectations. On the same note, Reinhard and Horwitz (1995) argue that grandparent caregiving is normative in black communities and that black caregivers appear to suffer fewer burdens than their white counterparts from equivalent levels of responsibilities. Reinhard and Horwitz (1995) deduce, however, that the differences may be due to cultural factors that influence the conception of a burden, which is not to say that the experience of grandparent caregiving is not experienced as a hardship. Therefore, the role is not always freely chosen but is adopted because of familial expectations and cultural norms, leaving little room for planning.

Winston (2003) states that the maintenance of a strong kinship bond is a vestige of traditional African family structures that has made it possible for families to survive from slavery to the present. All the grandmothers in her study were committed to, and comfortable in, their roles as caregivers for their families. The majority of these

grandmothers were following a family tradition of parenting grandchildren. Winston (2003) further states that it is significant that the majority of the respondents enjoyed close relationships with the children's mothers and expressed pride in being called on to emulate a role that had been vital in their lives. It seems that the incentive to turn from thoughts of loss and death to reminders of life and growth stemmed from the daily interaction with their grandchildren. The contact offered them an opportunity to experience the primary parenting experience or to rework previous parenting practices that may have been deficient. This, according to Erikson (1982), may provide a meaningful interplay between one's beginning and end as well as some sense of summary, and possibly, a more active anticipation of dying, having accomplished the role of grandparenting.

According to Winston (2006), the predominant reason why grandmothers care for their HIV-infected adult children, and parent their grandchildren after the latter's demise, is the belief that families come first and should stay together at all costs. Thus culture has a role to play when it comes to child rearing in most societies. However, the grandmothers in Winston's (2006) study were experiencing a role shift from grandmother to primary caregiver. Findings from Safman's (2004) study indicate that grandmothers caring for orphaned grandchildren describe the need to resume economic activities outside the house in order to meet their vastly inflated economic needs.

### **2.3.2 HIV/AIDS and rural influx**

Rural areas in Zimbabwe are characterised by poor road networks, lack of running water and electricity, poor infrastructure in terms of schools and clinics, no proper sanitation, and are generally cut off from major cities. In a study conducted by Foster, Levine, and Williamson (2005) on the global impact of HIV/AIDS on orphans and vulnerable children, it was established that rural areas experience an influx of ill patients when these patients' situation deteriorates. The authors cited the example of Zimbabwe where the number of chronically ill patients was said to be proportionally greater in rural areas, indicating that the going-home-to-die phenomenon continues in most communities.

Similarly, in a study of AIDS-affected households in South Africa, one in ten patients had sent a child to live in another household, usually with an aged relative (Families tipped into destitution, 2002, cited in Foster et al., 2005). Consequently, two basic scenarios grandmothers often encounter are: an ill mother returns to her parents' village, taking her children with her, but dies soon afterwards, or, a widower in an urban area sends children to live with maternal relatives in rural areas (Foster et al., 2005).

Matshalaga (2004) found the same patterns regarding grandmothers and orphan care in Zimbabwe. She argues that, once people are frequently ill, they lose their jobs and, subsequently, their source of income for sustaining themselves in an urban setting, and often have no choice but to find their way back to the rural area to ensure the care and security of their children. Another factor contributing to this rural influx is that hospitals are increasingly unable to cope with HIV/AIDS-related illnesses, and tend to discharge ill patients prematurely, expecting these patients' relatives to care for them. However, those relatives in the rural setting are usually poorly prepared for taking care of these patients (Matshalaga, 2004).

Citing the influence of gender in relation to this illness, Matshalaga (2004) argues that when wives become very ill, they usually return to their own maternal homes to be cared for by their mothers. This is part of Shona culture, which usually sees the wife as a *mutorwa* [one who is not a full member of the clan], an outsider to the family into which she marries. As a result, when a wife becomes ill, the husband's family prefers to send her back to her original home. These women will take their children with them if the *roora* [bridewealth] was not fully paid for. Matshalaga's (2004) found that most grandmothers entered the scene by simultaneously caring for their ill adult children as well as assuming responsibility for their grandchildren.

According to Meursing (1997) the Shona and Ndebele people deal with the situation differently. Meursing (1997) asserts that among the Ndebele, the interaction between town and rural homes is lively. The rural home has had a central function in dealing with illness, and since colonial times, it has been the social safety net for ill relatives who

could not fend for themselves in urban areas. Meursing (1997) found that most rural homes are occupied mainly by women and elderly or ill men, and wives and grandmothers are expected to do the nursing. Rural homes are chosen for care because most food is grown locally, hence there is easy and affordable access to it, and also easy access to rural traditional healers who are believed to be especially powerful.

### **2.3.3 Nobody except grandmothers**

Alpaslan and Mabutho (2005) identified that in rural Botswana, orphans stay with their elderly grandmothers as caregivers because the latter are, often, the only available caregivers in the extended families. Suffice it to say that with their passing on, there will be no reliable caregivers. The authors further argue that grandmothers raising their grandchildren rarely seek out their new role, but it is rather thrust upon them. Jendrek (1994), on the other hand, argues that US grandmothers may elect to provide care when the child's parent is too young or too ill to act as a parent. These circumstances often propel grandparents into action, with the immediate objective of providing their grandchildren with a secure and supportive home environment.

Meursing (1997) established that among the Ndebele, most grandmothers upon hearing of their children's illness (daughters especially) respond by going to collect them from their homes. The most worrying thing here is that male children usually incline more to their in-laws after marriage, neglecting their families of origin, but turn to their traditional kin for assistance in times of crisis. Hence grandmothers face a situation where other children try to reconnect with them, where no familial relationships had never existed or had deteriorated. They end up caring for these children, as they feel obliged to, since the extended family's capacity can no longer absorb them.

Among Kenyans, Ayieko (2005) found that many women infected with HIV/AIDS migrate back to their maternal homes during the later stages of their illness. Other women return to their homes because they are too frustrated by their in-laws to continue living with them. Maternal grandmothers thus end up taking care of their returned daughters and

grandchildren simultaneously. Evidence, however, revealed that because of a lack of counselling services for these caregivers, a number of caregivers experience caregiving fatigue, mostly because of high demands on their time, particularly for nursing ailing children. Among the Kisumu and Siaya people of Kenya, it was observed that tradition does not allow one to turn down such an assignment of absorbing orphans into one's household, and the assignment is mostly done by the village elderly women.

Among the Tswana people of Botswana, Burman (1996) found that it is not unusual for older Tswana women to foster grandchildren. A daughter would send her children to her mother and, even on some occasions, to the mother of the children's father to provide household assistance and other tasks. The fosterage system furnished both children and women with structures of support, grounded on reciprocity. Women would receive assistance with household tasks and children would receive care and training. In recent years, however, with increasing numbers of deaths due to the HIV/AIDS epidemic, greater numbers of children are living with and being supported by women relatives. The fosterage system remains in place but is being stretched to the limit, as there are greater numbers of children and fewer older women and resources to take care of them. It seems that the fosterage system has changed from a reciprocal relationship to one where the purpose is largely the care of AIDS orphans.

## **2.4 CHALLENGES FACED BY GRANDMOTHERS CARING FOR ORPHANED GRANDCHILDREN**

### **2.4.1 Socio-economic and physical constraints**

Safman (2004) investigated HIV/AIDS orphans and their caregivers in Thailand and found that the dominant concern of caregivers of orphaned grandchildren is the costs associated with child rearing in an increasingly market-based society. As a result, caregivers bemoan the costs they face and predict that their experiences will worsen as the children ascend to secondary school. Concerns arise as continuation of formal education through to the end of secondary school is viewed as a necessity, given



prevailing trends in labour markets. For this reason, grandmothers face economic burdens coupled with stresses, since they can find no solutions to most problems, which may lead to a chain of poverty if their grandchildren do not receive formal education (Safman, 2004).

Ansell and Young (2004) link poverty to the economic burdens faced by grandmothers, and argue that, although grandparents would seem to provide more sustainable situations than other relatives, they are sometimes unable to accept children on account of poverty. Ansell and Young (2004) further argue that when children choose to leave their grandparents' homes, it is usually poverty-inspired. In the light of this thinking, Wilson and Adamchak (2000), in investigating Zimbabwean grandmothers, focused specifically on diminished resources among these grandmothers' households. The authors conclude that these fewer resources reduce the already overstretched ability of older Zimbabweans to maintain their fitness and nutrition. The authors also note that it is inevitable that older Africans and, in particular women who will outlive their husbands, will shoulder the consequences of HIV/AIDS. This often occurs without concomitant formal or informal mechanisms to enable these women to manage. Wilson and Adamchak (2000) conclude that, 'This is why HIV/AIDS is already referred to as the "grandmother disease" in many of the villages in rural Africa' (p. 6).

According to Foster, Makufa, Drew, Kambeu, and Saurombe (1996), owing to the economic hardships faced by grandmothers, living with these grandmothers is potentially a vulnerable situation, since, as the HIV/AIDS epidemic spreads, grandparents are robbed of one of their main economic support mechanism: their sons and daughters. Therefore, grandparents who have expected to receive assistance from their children, now struggle to find ways to support and care for their orphaned grandchildren. To add to this, Wilson and Adamchak (2000) argue that older Africans, as illustrated by the situation in Zimbabwe, have historically relied on informal support in the form of cash transfers from their children, together with small-scale agriculture and some small-scale trading. These authors, however, note the changes in the traditional family system, claiming that in most developing countries, the family or the extended family is the most important support

mechanism for older people. Wilson and Adamchak (2000) cited the Zimbabwean scenario where the development process has altered traditional institutional structures, with, especially older women, receiving less support from their families than did prior generations. Erikson (1982) cautions that this may lead to a continuing sense of stagnation, resulting from an existential sense of meaninglessness, wishing their lives had been different from their present situation.

In her study on grandmothers and orphan care in Zimbabwe, Matshalaga (2004) found that grandmothers would provide extensive care for their grandchildren in a situation of severe poverty. She further highlights that the care of ill adults and their children contributes to the gradual impoverishment of the grandmothers' households and leads to serious difficulties meeting children's basic needs, such as, clothing, shelter, food, and access to health care and education. Foster et al.'s (2005) findings share many of the same conclusions: that the economic toll of HIV/AIDS starts with eroding the resources of the person living with the disease, then depletes the resources of the immediate and extended family, and eventually, threatens to overwhelm the capacity of communities to act as a safety net.

Foster et al. (2005) argue that once an HIV infection begins to deteriorate into chronic illness, its economic impact makes itself felt. According to Foster et al. (2005), the grim reality of HIV/AIDS is that its economic impact can become so severe that adult members of a household can no longer continue income-earning activities. These authors further argue that HIV/AIDS puts enormous economic stress on households when they care for sick family members, experience the loss of productive adults, or take in orphans. Therefore, the slide from relative comfort to destitution can be frighteningly quick. Hence, illness in these grandmother households does not cause poverty, but rather worsens its legacy. The greatest economic impact of HIV/AIDS stems from the high costs of treatment and families may go out of their way in depleting resources, trying to save the patient's life.

According to Meursing (1997), in investigating HIV in Matabeleland, Zimbabwe, developing or maintaining a degree of economic security in this long-drawn out and progressive illness is a most important facet of living and coping with it. The multiple illness episodes mean costly treatment is necessary. In addition, the illness reduces the family's capacity to earn an income, as it tends to affect wage earners in the most productive years of their life. Meursing (1997) found that individuals and families, especially grandmother led households whose economic situation is already marginal, are most vulnerable to sliding into destitution. Hence, as poverty threatens the quality of life of surviving family members, its effects often escalate. Meursing's (1997) findings suggests that even after patient(s) had died from AIDS, surviving family members experience great difficulties in overcoming the economic downfall set in motion by the illness. Subsequently, Meursing (1997) argues that the prospects for orphans are often bleak, and are set to become even more bleak with time.

As Meursing (1997) further avers, the financial burdens of medical care for the affected family are extreme. Infected persons find themselves poverty stricken due to their loss of earning power as well as the high cost of treatment. As a result, grandmothers are forced to go out of their way in trying to sustain the life of the infected persons, even by selling livestock. According to Meursing (1997), the death of a breadwinner often results in the total breakdown of the nuclear family, the bereaved survivors frequently return to the village where the expected breadwinner is the aging grandmother. Subsequently, parents who thought they had finished caring for the physical needs of adult children, often find themselves caring for their children and grandchildren as well. Often, caring for their children and grandchildren involves tasks that were never expected at an old age, and which are perceived as particularly difficult (Meursing, 1997). This may lead to despair in old age as a result of failing to achieve what Erikson (1982) refers to as an averagely expectable experience, reflecting an affirmation that one's life has been a meaningful adventure in history.

Many rural households in Zimbabwe rely on subsistence agriculture, which is very labour intensive and entails a wide range of activities to ensure that crops are produced. These

include, among others, clearing the fields, planting, weeding and harvesting crops, tending the animals, and working in vegetable gardens. Important is that when crops are ready for harvest, the crops also have to be transported to the homesteads. As Matshalaga (2004) notes, shelling and threshing grain is an after-harvest activity, also demanding human labour. Further essential chores include fetching firewood and water, securing relish, making fire, cleaning the homes, doing household laundry, repairing homes, and engaging in income-generating activities. Matshalaga (2004) adds that much of the work is very time-consuming and repetitive. This further highlights the plight of these grandmothers when one considers that they often have no one to assist them in the long run, yet the feebleness of their bodies is inevitable.

Consistent with Matshalaga's (2004) conclusions is the work of Karim and Karim (2005), which hinges on the challenges faced by rural women giving care to orphans and their dying parents. The authors argue that, since in most rural areas it is the women who undertake subsistence farming, the added burden of caring for orphaned grandchildren in turn exacerbates nutritional problems in these communities as it begins to have an impact on production time for subsistence farming. These authors maintain that households like these are already vulnerable because of the limitation of economic opportunities for women. The situation, however, becomes even worse when traditional norms and customs too often see widows being severed from the extended family and denied access to land and housing (Karim & Karim, 2005).

Meursing (1997), in support of the above assertion, claims that in Matabeleland droughts are quite common and thus water, essential for nursing, has to be fetched from far away places. Some years, the raising of crops becomes impossible, and food scarcity makes dietary adjustments impossible. Nursing in a rural home is, therefore, often extremely hard on caregivers, especially aging grandmothers.

Matshalaga (2004) emphasises the impact of environmental change on the lives of orphans. Some children, in Matshalaga's (2004) study, were previously living with their parents in urban settings and grandmothers, therefore, were obliged to handle most of the

acclimatisation of such children to rural life. Notwithstanding the struggles and stress of managing their households under extreme poverty, these grandmothers were found to provide their grandchildren with the identity of a home and family love. Matshalaga (2004), however, argues that counselling and psychosocial support, which are difficult enough to find at the best of times, become a luxury when even basic survival needs are difficult to obtain. Consequently, even without the necessary skills for childcare and counselling, grandmothers have no option except to employ the little knowledge they have to make these children feel at home.

Meursing (1997) identified that social isolation is another aspect that haunts the caregivers of both HIV/AIDS patients as well as orphans. This usually results from fear of stigma and is a most challenging problem facing most grandmothers of HIV/AIDS affected families. Meursing (1997) further observes that few social supports are offered to this population and this stigma is retained, even following the death of the persons with HIV/AIDS. Social rejection tends to make itself felt when symptoms become so severe that lay persons can recognise them as being HIV-related. Society's reaction to affected families, therefore, often results in social rejection, as the disease is linked to socially condemned behaviours such as promiscuity and prostitution.

Another challenge identified by Meursing (1997) is that of reduced participation in social activities since community members may avoid the family for fear that the grandchildren are infected. Intra-familial relations may become strained if conflict over custody arises or the grandparents judge other family members to be negligent about shouldering adequate responsibility.

#### **2.4.2 Gender and discriminatory practices**

According to Matshalaga (2004), the cultural practice where a deceased adult's property is shared among relatives, has a direct negative impact on the care of the remaining orphans. Often the children find themselves with no resource base to sustain their livelihoods. Grandmothers in Matshalaga's (2004) study often inherited nothing but the

orphans. In line with these findings, Donahue (1998, cited in Foster et al., 2005) found that after a husband's death, his widow and children may lose household assets and even their home itself since property is often being seized by the husband's relatives. Donahue postulates that claiming property may have some justification under traditional law, but it can disenfranchise women and children and drive them quickly into poverty. In addition, in many countries it is the widowed grandmothers who take on the burden of caring for their grandchildren and under such circumstances experience severe economic stress as a result.

According to UNICEF (2003), gender and cultural practices that marginalise women, account for high levels of poverty amongst households headed by women in Zimbabwe. The male-dominated nature of society limits women's ability to achieve economic independence. Traditionally, women did enjoy some entitlement to land, but they could not inherit their husband's property, rather, when a husband died, the widow, children, and other possessions were inherited by his male relatives (Meursing, 1997). These customs contribute to heightened vulnerability, especially amongst households headed by old women (UNICEF, 2003).

### **2.4.3 Changing lifestyle of grandmothers**

HIV/AIDS inevitably alters a family. It moves its members into an environment of profound change, turmoil, confusion, and anxiety. According to Meursing's (1997) study, none of the grandmothers anticipated, or had foreseen, a chronic illness like HIV/AIDS in their families, let alone the consequences of the illness. Grandmothers in Orb and Davey's (2005) study complained that raising grandchildren altered their dreams and created new tensions and struggles. Most of these grandmothers were resentful of not being able to enjoy life as a retiree and not having the freedom to feel free. Others expressed that they were resentful of their own children for not taking the parenting role. Most of the grandmothers also worried about the uncertainty of their future. Old age to these elders becomes the opposite of what Erikson (1982) claims as the averagely expectable experience to be anticipated by means of planning, and which should provide

a meaningful interplay between one's beginning and end. It might be that what these grandmothers had planned and hoped for about old age could, however, not come into reality, but rather resulted in despair over the channel their lives took.

Winston (2003) states that parenting grandmothers are at a stage where the developmental tasks include shifting energies from physical attractiveness and strength to mental activities. Peck (1956) argues that this developmental period is characterised by the need to relinquish inflexible patterns of response in order to discover alternate coping strategies when new situations arise. For Winston (2003), although grandparents historically offered instrumental and affective support to their children and grandchildren in times of need, grandparents across ethnic and racial divisions are taking on an 'unplanned parenthood' role. She further asserts that grandparents once offered to assist in the parenting function with the tacit understanding that the biological parent would, at some juncture, take over full parental responsibility

Often grandparent caregivers experience a sense of being held to a different timetable from that of their peers. In a study conducted by Landry-Meyer and Newman (2004), grandparents expressed feelings of a sense of incongruence because of the inability to achieve developmental tasks that they believe to be appropriate for their age group. More than 50 percent of the participants in the study expressed that they feel an 'incongruence between life stage and parental role enactment' (Landry-Meyer & Newman, 2004, p. 168). Grandparenting on a full time basis at a later stage in their lives, disturbs the normal aging process of grandparents, therefore, interfering with Erikson's psychosocial development stage of integrity.

To add to the above, many grandparents find themselves losing touch with friends, because their daily activities are different from their peers and they grieve this loss at a time when they should be deepening their friendships, which causes further incongruence (Lever & Wilson, 2005). Caregivers in Lever and Wilson's (2005) study also raised their expectations as having been in the phase of 'empty nest' and 'retirement' at this age. Bodily aches and pains, as well as feelings of constant fatigue, were raised and related to

how it interfere with parenting skills in the home. Lund (1989) found that changes in social status or role occur when a wife becomes a widow. Friends and family may respond to this alteration in such a manner that it results in social deprivation for the widow. This deprivation is evident in the avoidance of the bereaved person and a general lessening of contact with others. In losing a companion, widows tend to lose contact with others. In addition to losing a companion, widows tend to lose contact with married couples, previously friends with them and their spouses. Widowhood may thus exert a long-term negative impact upon the friendship networks of older people.

From a financial perspective, grandparents raising grandchildren often experience parenting stress and financial difficulties. Orb and Davey (2005) found that grandparents are often confused about their entitlements and overwhelmed with the paper work required when approaching government departments. This confusion is exacerbated by the lack of appropriate information and sources of support available to them.

The process of normal aging can be disturbed by the sudden parenting role imposed on some grandmothers. This is supported by Lever and Wilson (2005) who claim that it is not surprising that many grandmothers have conflicting feelings about becoming parents again. These authors assert that often grandmothers are happy to be able to provide for the grandchildren, yet angry that they have been forced into raising another child or children. In addition, Strom and Strom (1993) found that the conflict engendered by feelings of resentment toward those who created the situation, guilt about things they might have done wrong as a parent, and doubts about their ability to manage by themselves, is quite common.

In addition to managing caregiver challenges related to children's health and frequent daily hassles, grandparents might, simultaneously, be dealing with life stage stressors related to performing an off-time role, such as financial worry, role ambiguity, personal adjustment to daily lifestyle, and re-evaluation of life goals. Therefore, under these circumstances, morale could suffer and grandparents might view their life quality negatively (Gerald, Landry-Meyer, & Roe, 2006), which is again reminiscent of



Erickson's psychosocial theory of development in late adulthood. When a woman assumes the grandmother role at an off-time period, given her generational position, she may experience what Lehr (1982, cited in Bengtson & Robertson, 1985) terms 'crisis accumulation.' Parenting and grandparenting demands, coupled with work and stemming from other generational family members, place these women in a vulnerable position to experience role overload.

Foster et al. (2005) conclude that, despite the differences in culture, resources, and experiences with the disease, there are also strong similarities at the most basic human level between the US and other areas affected by the global epidemic. These are: parents grieve the deaths of children, grandmothers take on the role of caring for their grandchildren, and children's lives are irrevocably altered by a parent's death. Therefore, there is much in common and much to learn from each other, even as different strategies are pursued to treat the wounds.

## **2.5 LOSSES IN ADULTHOOD**

When it rains, it pours is the expression we learn to use for times when losses such as deaths or accidents or illness in our personal lives come in multiples. (Viorst, cited in Harvey, 2002, p. 14)

Life stress and distress may be at their highest during periods of losses caused by deaths, accidents or illness. Multiple losses occurring for an individual in a brief period of time are often associated with multiple bereavements that are unremitting over time (Harvey, 2002). Worthy of note as well is the idea that a mediating variable in the influence of perceived chains of loss events may be a sense of whether or not the losses seem warranted in terms of justice or timing, as suggested by Harvey (2002).

### 2.5.1 Loss of a spouse

Widowhood is particularly common among older grandparents. Although, grandfathers whose wives die are likely to marry shortly, grandmothers are not (Bengtson & Robertson, 1985). When their spouses die, most grandparents lament that they have lost the future they had planned for, and that their dreams are shattered. Erikson (1982) argues that these grandparents seem to be mourning not only for time forfeited and space depleted, but also for weakened autonomy, lost of initiative, and lack of intimacy. Harvey (2002) found that soon after the loss of a spouse, older women (average ages in their 60s) show greater depression than similarly aged men and that both bereaved women and men exhibit greater depression than similarly aged non-bereaved control groups. The problem raised is, that when older persons exhibit normal responses to bereavement such as lack of energy, confusion, loneliness, and social withdrawal, these behaviours are sometimes interpreted as problems reflective of old age (Harvey, 2002).

According to Lund (1989), becoming widowed is a difficult life transition for most, and for some, it is a devastating personal crisis. The death of a spouse is not only an emotional loss but also a social loss, and it often entails major changes in life style and role performance. It is argued that bereavement can exacerbate existing mental and physical health problems, and it appears to have a role in precipitating new illnesses (Lund, 1989). Lund (1989) concludes that changes in social status or role occur when a wife becomes a widow.

In Brubaker's (1977) view, because women tend to marry older men, and because men die earlier than women, widowhood is primarily a female phenomenon. Brubaker (1977) further suggests that the surviving spouse might have been significantly involved in caregiving activities. Though the death is, therefore, expected and some preparatory grief may have begun, adjustment to the loss is complicated by the dual need to adjust to the death as well as the end of the caregiver role, and the accompanying feelings of grief intermingling with relief. Brubaker (1977) argues that widowhood entails two major

challenges, that of resolving the grief over the loss of a loved one and building a new life as a single person.

Closely linked to the loss of a spouse is the issue of divorce. In a study carried out by Farnsworth, Lund, and Pett (1989, cited in Harvey, 2002) it was reported that divorced participants experience significantly more difficulty with anger, guilt, and confusion, and that widowed participants are significantly more depressed.

### **2.5.2 Loss of a child**

They say, when you bury your parents, you bury your past.  
And when you bury your spouse, you bury your present. But  
when you bury your child, you bury your future. (Anonymous,  
cited in Harvey, 2002, p. 31)

The death of an adult child may be deeply disturbing for older people. In fact, it has been argued that this is the most difficult of all grieves to resolve (Stevens-Long & Commons, 1992). Not only is the death usually untimely, but as mentioned earlier, the parent also suffers guilt at having survived the child. An elderly person may also feel competition with the spouse of an adult child for the place of the 'most bereaved' (Stevens-Long & Commons, 1992).

In line with the above, Cook and Oltjenbruns (1989) consider that the death of a child is traumatic for parents regardless of the age of the child. Death of a child, when compared to other types of losses, has been shown to produce the most intense grief and the widest range of reactions (Cook & Oltjenbruns, 1989). When a child of any age dies, the death disrupts the anticipated order of the generational cycle. In the case of the death of an adult child, aged parents may ask why their lives have been spared when their offspring were taken in the prime of his/her life. The death of an adult child may also result in additional crises for, and compound, the grief of the older adult. Adult children are often caregivers for their aging parents and their absence may leave the latter with little or no

assistance (Cook & Oltjenbruns, 1989). Jeffreys (2005) claims that adult children represent potential caregivers of the aging parent and such deaths increase fears about not having care needs met in the future.

From a developmental perspective, the bond between elderly parents and their adult children is unique. The older parent who loses a child generally views the relationship from a lifelong developmental point of view, and the image of the child spans a long time frame: from childhood through adulthood, and is tied to the survivor's history as a parent (Cook & Oltjenbruns, 1989). The death of an adult child can threaten the aging parent's sense of continuity and generativity, which is, according to Erikson (1982) important for successful aging. If the deceased had been seen as the one to carry on the family name or was the primary person responsible for running the family, the aging parent may, as well, feel that the future of their family is at stake (Cook & Oltjenbruns). Harvey (2002), on the other hand, argues that a frequent reaction of parents to the loss of a child is that of survival guilt, and grandparents may feel that it is not fair that their child died while they are still alive.

In Smith's (2005) view, the loss of a child in adulthood represents a situation whereby, for most grandparents, their world will be turned upside down. There is the belief that parents are not supposed to outlive their children, so that the bereaved parent is forced through a crack in the universe into a world where expectations are turned inside out. On the other hand, from a psychological point of view, Smith (2005) found that parents who depended heavily on a child for need-fulfilment can also experience complicated responses. As a result, the child may have filled the gap left by a physically or psychologically absent spouse. Hence bereaved parents may feel that their core identities have been ripped out and a 'chasm exists between the person that I was and the person that I am' (Smith, 2005, p. 123).

For Hindmarch (1993), the enduring pain of losing a child cannot be measured, so that it is not possible to say that it is more, or less, painful to lose a child suddenly or after a long debilitating illness, nor can it be assumed that the age of the child determines the

intensity of the emotions. Hindmarch (2000) summarises entire set of losses experienced by grandparents, by concluding that these aging parents will be grieving for a part of their own self, physically, emotionally, and spiritually, their connection to the future, unfulfilled expectations and ambitions, source of love and acceptance, a sense of power and control over what happens to them, and social status. Therefore, the critical task as postulated by Erikson (1982), will be for the elderly to evaluate their life's accomplishments, resulting in either a sense of integrity or one of despair.

### **2.5.3 Loss of a grandchild**

The grief suffered by most grandparents when they lose a grandchild is three-fold; they grieve for the loss of life their deceased grandchild has suffered, for their own children's grief, and for their own loss of the grandchild (Smith, 2005). To most grandparents, grandchildren represent a continuing link with the future at a time of life when one is increasingly aware of one's own mortality. Some grandparents will have been involved directly with the care of the child; and in such cases the grandparent takes on a parenting role and the intensity of grief is more akin to that of a parent (Hindmarch, 2000). Erikson, Joan, and Kivnick (1986) state that during old age, there is much sorrow to cope with, plus a clear announcement that death's door is open and not so far away. Therefore, even those who enter old age with a high degree of integrity experience despair at the momentarily thought of death, and disgust at the futility and pettiness of human life.

Oikonen and Brownlee (2002), in a descriptive study of the reactions of grandparents to the death of a grandchild, found that 56 percent of the grandparents in their study reported feelings of numbness, shock, and disbelief upon hearing of their grandchild's death, while 64 percent became physically symptomatic following their grandchild's death. On the other hand, Ponzetti (1992) argues that grandparents are also reported to be suppressing their feelings of sorrow in order to shelter their families from further anguish.

To add to the above, grandmothers in Ponzetti's (1992) investigation reported feelings of guilt upon the death of a grandchild. The guilt they reported appeared to be related to the

possibility that the death could relate to a genetic predisposition or chromosomal abnormality and that they might be the original genetic carriers of a certain anomaly (Ponzetti, 1992). These grandmothers reported survivor guilt for outliving their grandchild. Given that the parental instinct to protect one's children from pain continues throughout the lifespan, when adult children are burdened with the death of a child, grandparents feel unable to fulfil their natural parental role (Ponzetti, 1992). Such negative feelings may lead to a sense of despair as one feels that their lives should have been different from what they are, since the critical stage at late adulthood is to evaluate one's life accomplishments (Erikson, 1982).

#### **2.5.4 Loss of health**

According to Smith (2005), for many grandparents, the realisation of severe limitations on their own abilities creeps in subtly and gradually as they find themselves increasingly unable to attend events outside their homes. A study conducted by Alpaslan and Mabutho (2005), found that elderly caregivers all reported experiencing health problems, either from old age or from the stress suffered as a result of a child or children, being lost from HIV/AIDS-related diseases. In support, Olshevski, Kartz, and Knight (1999) argue that, owing to the stress of caregiving, elderly caregivers may enter higher health risk categories than those dictated by old age alone.

May (2003) refers to a World Health Organisation assertion that:

Although the health of elder caregivers is arguably their most precious asset not only to them, but to their families and communities; they are finding it difficult to access needed health services for themselves and the orphans they care for due to high cost, distance, and the often negative attitudes of health workers towards AIDS orphans and caregivers. (p. 19)

Consequently, the situation further hinders most caregivers from providing adequate care to orphans, as they are the only ones left to be economically active, yet their own health problems challenge them and prevent them from earning a decent income.

Alpaslan and Mabutho (2005), in a study in rural Botswana, found that grandmothers caring for orphans faced challenges of lack of support from the children's fathers and the extended family, leading these grandmothers to seek part time jobs under extreme conditions. The grandmothers also cited difficulties with government grants, that prevent them from providing for the orphans' basic needs. In a study conducted by Yamba (2003) in Zambia, it was reported that grandparents who were left to care for orphans were frail and weak, which made it clear that the orphans could soon be going through yet another bereavement within a short period of time.

Equally important, but nevertheless neglected, is the need for good health among the grandparents caring for orphaned grandchildren. In support of this view are Wilson and Adamchak (2000), who contend that most African governments wish to compete in the international economic system and to enhance their developmental process, but most programmes are not considered for older citizens. It seems that governments may, when they are preoccupied with development issues, view older citizens as not providing a suitable return on their investment. Rather, investing in capital improvements is seen to yield a favourable return, but more often than not, investing in older people is viewed negatively. It is noteworthy that formal health education is not even aimed at older people, as they are deemed least likely to contract HIV. What is often forgotten is that their households are victims of HIV/AIDS and they may be caring for infected orphans, having once cared for their infected late parents, hence increasing the chances of their contracting the virus (Wilson & Adamchak, 2000).

Oburu and Palmerus (2003) established that in Kenya, caregiving by elderly citizens has been linked to higher levels of psychological distress, role confusions, and worsened psychological health amongst grandparents when their traditional limited roles and freedom to enjoy lives of their own are interfered with. While it was not rare in the

traditional three-generation Kenyan Luo homesteads for grandmothers to provide limited child-minding duties, it was anticipated that, because of the magnitude of the AIDS orphan crisis, when many families have been affected and traditional African familial support systems have been broken down, full-time adoption would also be similarly linked to higher levels of caretaking stress amongst these Kenyan grandmothers (Oburu & Palmerus, 2003). Erikson et al. (1986) caution that, as a result, despair may haunt late adulthood as losses of physical ability are imminent, independence and control are challenged, and self-esteem and confidence will therefore weaken.

## **2.6 GRANDMOTHERS AS GRIEVERS**

Kübler-Ross (1975) proposed five stages of the grieving process, which she considered to apply to both the grieving process after the loss of a loved one and that following diagnosis of a chronic illness. The first stage is denial, where, in the present scenario, the grieving grandmother learns that her child is terminally ill and denies the fact. According to Kübler-Ross (1975), denial is important and necessary as it helps cushion the impact of the caregiver's awareness that death is inevitable. Anger comprises the second stage, when the grandmother will resent the fact that other people's children will remain healthy and alive while hers must die. Kübler-Ross (1975) relates that God is a special target of anger during this stage, since He is regarded as arbitrarily imposing the death sentence.

The third stage is that of bargaining, where, in this scenario, a grandmother might be bargaining with God to give her ill child more time and promise to do good, in exchange for another week, month or year of life. Depression constitutes the fourth stage, where victims of grief await the arrival of death, in this case, that of the HIV/AIDS patient. Finally, there is acceptance, which according to Kübler-Ross (1975), is neither a happy nor an unhappy stage, it is devoid of feelings, but is not resignation, rather, it is victory. One should note, however, that the stages proposed by Kübler-Ross (1975) are not absolute and that not everyone goes through every stage in this exact sequence, at some predictable pace.



Grief, according to UNICEF (2002), is a normal reaction to loss. It is experienced as feelings and emotions, while it also preoccupies the mind in the form of thoughts and worries. Some people may go to the extent of pondering the meaning of life and query existential issues at a spiritual level (UNICEF, 2002). There tend to be physical manifestations of grief as a grieving person can be seen to be sad and sometimes depressed. Grief is usually intertwined with bereavement, which refers to a sense of loss and the grief and mourning process that accompanies it, as postulated by UNICEF (2002). In addition, Hindmarch (2000) defines bereavement as what actually happens, grief as what one feels in reaction to the bereavement, and mourning as what one does to express grief. Hence most grandmothers, taking care of their ill children, may begin to mourn during the illness and experience most of the psychosocial emotions related to anticipated loss and grief.

Rybash, Roodin, and Hoyer (1995) have proposed types of grief, which manifest themselves differently among different individuals. Rybash et al. (1995) identify two different types of grief: first, *delayed grief* which emerges long after the deaths of those we love. The second is *anticipatory grief*, which actually begins prior to death. The latter form is the anticipation of a death that is virtually guaranteed to occur. The grief-work may begin weeks or months in advance of the actual death. However, there is no evidence that anticipatory grief makes adapting to the actual loss easier (Rybash et al., 1995).

According to Dane and Miller (1992), some grandparents experience *shadow grief*, which these authors define as a form of chronic grief experienced by mothers that does not manifest itself overtly. Retention of grief in this form is said to be most likely the result of two related factors that may not operate in other types of losses, the first of which is the desire of mothers never to forget their losses. These mothers want to remember all the details associated with the lost child and the circumstances surrounding the death. The second factor is the general inability of such a mother to express feelings to others, thus being unable to find legitimate avenues of expression; the need to remember becomes

pre-eminent, since the mother assumes that if she doesn't remember her children, no one else will (Dane & Miller, 1992).

Cook and Oltjenbruns (1989) found that, often, older people experience grief related to the accumulation of physical changes that occur with age. These physical changes are inevitable as individuals grow older and the changes may be perceived as states of loss or threats of loss. The most common physical losses are loss of sight and of hearing. Losing such crucial senses may be worrying to most grandmothers as they care for orphans who range from infants to teenagers requiring lots of work on their part.

Cook and Oltjenbruns (1989) argue that researchers have largely ignored the grief of grandparents. Grandparents are often more alone in their grief than any other group and they are often expected to cope well so that they can be of support to other family members, while, simultaneously, serving as role models. Consequently, being the remaining pillars of most families, grandmothers often grieve in isolation and in silence, which only worsens their situation. As stated earlier, the death of an adult child can threaten the older person's sense of continuity and generativity, which is, according to Erikson (1982) important for successful aging.

Winston (2006) argues that parental bereavement is considered extraordinarily severe when compared to other bereavements, while Shatz (1986) argues that maternal grief is a grief that is felt forever. As Shatz (1986) points out, the grief is not unresolved because the mother has not reached the acceptance stage of the grieving process, but instead, the mother has reached the stage of realising that she will live the rest of her life without her child or children.

According to Winston (2006), maternal grief is particularly intense and lengthy, given the unique relationship between a mother and her child that begins before birth, contributing to the intensity of the loss experienced. The loss is further necessitated by the memories created over the years. Erikson (1950) further highlights this point, arguing that because the parent who grieves the loss of an adult child is also grieving losses concomitant with

life stage transitions, the ability to achieve a sense of continuity and generativity may be compromised.

## **2.7 AFFECTED FAMILIES AND GRIEVING**

When a child's death is caused by HIV/AIDS, the likelihood that the mourning process will be hindered is increased, specifically because of HIV/AIDS's association with antisocial or stigmatising behaviours, including promiscuity (Winston, 2006). Thus the 'disenfranchising' death can create such shame, guilt, and embarrassment that survivors do not seek the traditional social support to sustain them as they grieve (Winston, 2006). Furthermore, Cox (2002) argues that many grandparents find it difficult to share with their grandchildren the fact that the parent was infected with HIV or had died of AIDS.

In researching HIV/AIDS in South Africa, Karim and Karim (2005) postulate the circle of silence, stigma, and disenfranchised grief. These authors argue that stigma is an insidious, complicated phenomenon that feeds upon, reinforces, and reproduces already existing inequalities of class, race, gender, and sexuality. They further claim that in South Africa, as elsewhere, stigma has gone hand in hand with discrimination based on a variety of perceptions and misconceptions of HIV/AIDS. Karim and Karim (2005) further state that stigma and discrimination cruelly warp the lives of those infected with HIV/AIDS and their immediate caregivers, but death, unfortunately, brings no further clarity to the widespread distortions of understanding. Most directly, this is to be seen in the way that grief itself is perverted or suspended for those who survive the complexities, which Karim and Karim (2005) can best describe as the disenfranchisement of grief.

Even in death, communities remain locked in denial, with all sorts of euphemisms being used to refer to an HIV/AIDS-related death. The aura of secrecy, stigma, and social ambiguity that surrounds such deaths leaves no pathway for the grieving process to follow (Karim & Karim, 2005). Thus the immediate bereaved are left unsupported to confront the bewilderment of pain, sadness, and fear, shunned very often by family and

friends, and by community or social networks, because of the generalised uncertainty and fear that veil an HIV/AIDS-related death.

According to Newness (1991), for families confronted with HIV/AIDS, anticipatory grief may become operative. It begins with observation of the weakening of the HIV/AIDS victim, repeated hospitalisations, and thus, absences from home, therefore signalling that the death or loss is imminent. The reaction to this is often sadness and despair. Expression of anticipatory grief may prepare family members for the death of the loved one. It is therefore of importance to note that death and bereavement take place in a social context. As postulated by Newness (1991), it is always important to study the influence of social and cultural factors on the process of mourning. Lopatta (1979) argues that grief is more rapidly resolved in societies where there is family and community support. However, in the context of HIV/AIDS, one of the most difficult aspects of bereavement is loss of role and status and subsequent social isolation. Bereaved people therefore suffer from a loss of roles, which is associated with problems in social interaction, and this may be reinforced by social stigmatisation.

Hindmarch (1993) found that some deaths carry an element of social stigma, presenting an added difficulty for families coming to terms with their grief, especially HIV/AIDS, which evokes highly emotive responses at a social level and may reduce the level of sympathetic support forthcoming in other situations. Bereaved families are thus likely to be further isolated. Against this background, it is all-important to note the assertion by Dane and Levine (1994) that secondary HIV/AIDS survivors experience trauma, shame, guilt, insecurity, and disorientation. There is also a tendency for affected families to deny, avoid, retreat, isolate, and wish to escape. These families experience intensely negative reactions that shape their behaviour and limit their effectiveness in achieving a healthy outcome to their grieving. This is usually the case due to societal assumption that people with HIV/AIDS are responsible for causing their condition through risky behaviour.

Dane and Levine (1994) view an HIV/AIDS death, and the effect it has on the survivors, from a spiritual perspective. The authors argue that death is a spiritual crisis, as it

demands answers beyond the realm of immediate experiences, yet the spiritual nature of the crisis has all but been ignored. According to Dane and Levine (1994), one common perspective in more fundamentalist and conservative faiths holds that HIV/AIDS is viewed as a divine punishment for moral failures. For this reason, most persons with HIV/AIDS are seen to be responsible for their affliction and deserve their fate. Hence for the remaining family, such mystifications may be spiritually draining as they question why their families became victims of such a shameful disease.

## **2.8 GRANDMOTHER-CAREGIVERS AND SUPPORT**

Matshalaga (2004) argues that, try as one may to deny it, grandmothers must, increasingly, bear the burden of care for large numbers of orphaned grandchildren with little or no support from the surviving members of the extended family or other sections of the community.

### **2.8.1 Government assistance**

Grandmothers in Matshalaga's (2004) study indicate that registration for assistance from government bodies is not adequate, since only a few households in a given village could be assisted, resulting in many needy households without assistance. Some grandmothers were obliged to use other means of raising food, for example, brewing beer for sale and selling fruits for a cash income (Matshalaga, 2004). This all reverts to the notion that grandmothers are fighting a lone battle as regards to care for orphaned grandchildren. Karim and Karim (2005) identify that in South Africa vulnerable communities and individuals become increasingly at risk of HIV infection as their access to health services is more and more compromised by their deteriorating economic and social circumstances. As a result, Karim and Karim (2005) maintain that although the writing has been on the wall for very many years, government and societal response has been desperately inadequate.

### **2.8.2 The extended family**

When a new epidemic strikes, coping strategies for dealing with it are likely to be built upon already existing strategies for dealing with illness and its consequences, such as the material and practical needs of the sick and care for widows and orphans (Meursing, 1997). Among the Ndebele and Shona people, as noted by Meursing (1997), there are well-practiced strategies for dealing with illness and other life crises in which the extended family functions as the most immediate resource for material, social and emotional support. Thus traditionally, there is no such thing as a relative who is too poor to help another. However, practical considerations have limited both the capacity and willingness of relatives to take on extra responsibilities. Moreover, urbanisation has whittled away the closeness of family ties, while economic pressures and the limits of urban accommodation have made families less able and willing to take one or several other children into their homes.

In addition to factors mentioned earlier, there are also instances where grandmothers inherit grandchildren from polygamous marriages. Matshalaga (2004) further asserts that, indeed, the whole concept of an orphan did not exist in traditional Zimbabwean society. However, the traditional extended family has over the years been weakened by the high mortality rates, and this has led to the situation described above, where grandmothers are caring for orphans, in many cases entirely unsupported (Matshalaga, 2004).

Ayieko (2005) found that Kenyan communities have been known for their spirit of support. Family and friends would unite in pooling resources together to help each other during major financial needs. Such devotion and attachment are slowly fading away as each family fend for its own survival. According to Karim and Karim (2005), relatives are now unable or no longer available to cope with the rising number of orphans. They further argue that the challenge of orphans is an unfolding tragedy in which the erosion of the family structure is set to continue for many years. One such finding of the study was that even if HIV infection rates drop, the number of orphans in Southern Africa will continue to rise as parents and the heads of households continue to die of AIDS-related

deaths. On the other hand, the extended family that would traditionally care for these orphans is less and less able to do so for reasons mentioned earlier, and so the traditions themselves break down and fade. It was also established that in some situations orphans cared for by the extended family were treated as second-class family members, exploited by being given excessive household chores, forced to drop out of school to contribute to shouldering the added financial burden of the extended family (Karim & Karim, 2005).

## **2.9 CONCLUDING REMARKS**

Grandparents usually do not expect to raise their grandchildren, and they may not be afforded time to adjust to this transition and to deal with their own emotions prior to assuming the role of child rearing. They often find their personal resources stretched to the limit in their capacity of surrogate parents for their grandchildren (Strom & Strom, 1993). Therefore, the emotional outcomes of their circumstances become overwhelming. Often, grandparents are gaining a grandchild but losing their own child in the process. In addition, some grandparents are confronted with a double-edged sword because they question their own competency. Likewise, grandparent caregivers are also faced with the reality of their aging, which, combined with rearing a child and the difficulties associated with raising a child, may further lead to heightened concerns about health problems (Mayer, 2002).

Similar thinking is evident in the work of Alpaslan and Mabutho (2005) who claim that the emotional strains resulting from negative community reactions towards the fostered grandchildren, or worries about the cost of childcare, may haunt most grandparents. According to Meursing (1997) most grandmothers have to cope with their own feelings such as anger and shame at their own children's disobedience. The cultural emotional restraint, the embarrassing nature of the illness, and caregivers' struggle with negative emotions may all contribute to the rather cursory and shifted emotional support between parental figures and children (Meursing, 1997).

It can be emotionally draining for most grandparents as they often do not possess the capacity to follow up on their deceased children's rights due to advanced age, ignorance, fear of being intimidated by relatives while pursuing the wealth, and feelings of helplessness at having lost a financial supporter (Ayieko, 2005). On the other hand, lengthy procedures and red tape for recovering personal assets have led many able bodied relatives to decline requests from elderly caregivers for assistance in doing so. As a result most grandparents live in emotional turmoil, since they, often, have failed to recover their deceased children's assets, yet they are usually, together with the orphans, in dire poverty.

Nursing someone with HIV/AIDS is a very heavy task, both physically and emotionally. According to Meursing (1997), the sickbed may be long drawn-out, and as patients often suffer from several diseases simultaneously, medical and nursing care is complicated, taxing, and costly. Meursing (1997) found that rural homes are often poorly equipped to deal with these needs, medical provisions are often far away, poorly staffed, and supplied, and difficult to reach because of infrequent transport. Grandmothers may experience physical strain and exhaustion, resulting from taking care of infants and younger children, as well as from work required to cover the escalating costs incurred in caring for the grandchildren.

Findings of the investigation by Orb and Davey (2005) show that these newly acquired parenting roles keep most grandparents busy and active. Grandmothers expressed tiredness as an overriding factor in their lives, since they have to meet the physical, emotional, and spiritual needs of the children as well as providing them with food, clothing, and shelter (Orb & Davey, 2005). Of interest is that these authors' findings did not indicate any difference between sole grandparents and those with a partner, which may question the role of men in caregiving practices cross-culturally, since women have always been confined to this area from generation to generation.

It seems that the experience of grandmothers as emerging caregivers have long been invisible, as research and treatment, have, too often, been directed at the needs of



younger generations. Grandparents have a plethora of needs that are, often, so overwhelming that these grandparents only have nostalgic memories of their past lives, which came to an abrupt end because of the passing away of their adult children. This investigation, therefore, embarked on investigating the psychosocial impact on rural grandmothers caring for their grandchildren orphaned by HIV/AIDS.

## **2.10 CHAPTER SUMMARY**

In this chapter, available literature has been reviewed, indicating that grandmothers are increasingly being recruited into caregiving of orphaned grandchildren. This occurs at a developmental age that, according to Erikson's psychosocial theory of development, is punctuated by either integrity or despair. The next chapter outlines the research design and method of the study.

## **CHAPTER 3**

### **RESEARCH METHOD**

#### **3.1 INTRODUCTION**

This chapter outlines the research method employed in the investigation. A description of the participants and the data gathering technique employed is furnished, explaining how data were gathered and analysed. The chapter concludes with ethical considerations and the limitations of the chosen method.

#### **3.2 THE RESEARCH DESIGN**

The purpose of the study was to investigate the psychosocial impact on rural grandmothers caring for their grandchildren orphaned by HIV/AIDS, and, as mentioned in Chapter 1, the study's theoretical development is derived from the gerontological concept of Erikson's theory of psychosocial development in late adulthood. The research question derived from the purpose of the study is: *What is the psychosocial impact on rural grandmothers in late adulthood caring for their grandchildren orphaned by HIV/AIDS?*

Therefore, in order to investigate the experiences of grandmother-caregivers parenting orphaned grandchildren, I undertook an exploratory qualitative study using in-depth interviews with 12 grandmothers in rural Zimbabwe. To achieve this, I employed interpretive research methods, which assume that people's subjective experiences are real and should be taken seriously, that we can understand others' experiences by interacting with them and listening to what they tell us, and that qualitative research techniques are best suited to this task (Terre Blanche & Kelly, 1999). These authors further assert that this assumption has translated into the idea that the meanings of human creations, words, actions, and experiences can only be ascertained in relation to the context in which they occur. Hence the design strives for depth of understanding.

According to Esterberg (2002), the goal of qualitative research is typically an in-depth, detailed study. Instead of making statistical generalisations about a large number of cases, the goal is often to tell detailed stories (thick descriptions) about a particular case or small number of cases. Similar sentiments are expressed by Bryman (2001), in whose view qualitative research is a research strategy that usually emphasises words, rather than quantification in the collection and analysis of data. I chose a qualitative research method because it assumes that valid understanding can be gained through accumulated knowledge acquired firsthand by a single researcher (Winston, 2003).

Tutty, Rothery, and Grinnell (1996) describe qualitative research as the study of people in their natural environment as they go about their daily lives. The authors add that qualitative studies attempt to understand how people live, how they talk and behave, and what captivates or distresses them. More importantly, qualitative research strives to understand the meanings, which people's words and behaviours have for them (Tutty et al., 1996). Therefore, from this qualitative stance, I sought to come to an understanding of the meaning that grandmother-caregivers attach to the experience of caring for AIDS orphans.

As indicated above, a qualitative research design was employed in the study, since it is richly descriptive. Merriam and Associates (2002) concur with this claim in the sense that words and pictures rather than numbers are used to convey what the researcher has learned about a phenomenon. In qualitative research, there are likely to be descriptions of the context, the participants involved, and the activities of interest. All these contribute to the descriptive nature of a qualitative inquiry.

Merriam and Associates (2002) also note a further merit of a qualitative research design, which refer to the fact that the researcher can expand his or her understanding of the phenomena under investigation through non-verbal as well as verbal communication, process information (data) immediately, clarify and summarise material, check with respondents for accuracy of interpretation, and explore unusual or unanticipated

responses. Therefore the qualitative approach was selected because grandmothers could describe their experiences in their own words and convey their feelings.

### **3.2.1 Research site**

Data were gathered in the Zimbabwean province of Masvingo, in the rural district of Gutu, among the villages of Makore, Mukaro, Mukadziwasha, and Utsinda (See Map 1 below). Utsinda was chosen to represent the two villages of Gutu Mission and Mushayavanhu, which were initially proposed as it is located between the two villages and covers a wider geographical area compared to these two. Gutu is shown on the map to the North East of Masvingo town, which is situated in the North of the province, and provides governmental services to all the other districts in the province, including birth and death certificates. The villages covered in the research study are not shown but all fall under Gutu district. I chose the particular setting as I hail from that province, which made accessibility to the villages easier. The other reason was that the province is located in a semi-arid geographical region, which makes life difficult for most inhabitants; thus the problem of HIV/AIDS may more or less exacerbate the already difficult circumstances of the inhabitants. Of note is that it is cut off from major cities, which may lead to questions of erratic service delivery.



**Map 1. Map of Zimbabwe**

Source: Automobile Association of Zimbabwe (AAZ, 2006)

### 3.2.2 Research Participants

Participants in the study were rural grandmothers in Gutu district, Zimbabwe, caring for their orphaned grandchildren on a full-time basis, following parental death or deaths due to HIV/AIDS. All of the participants are Shona speaking and live in Gutu district permanently. None of the participants were employed and only three are married, while the rest are widowed or divorced. Their ages ranged from 56 to 76 years, while the ages of the grandchildren ranged from newborns to 18 years. Four of the grandmothers were maternal, four were paternal, while the remaining four cared for orphans from both male and female deceased adult children. The majority of the orphans were under 12 years of age and girls outnumbered boys. As illustrated by Mayer (2000) the differences in the

grandchildren's ages posed various pressures on the grandmothers as each new developmental stage for the children and each shift in their life course signalled radical changes in their lives. This, therefore, posed parental challenges on the grandmothers. The grandmothers were mostly uneducated and struggled economically. Few of the orphans were attending secondary education. Rural grandmothers were chosen as most of them identify with their rural homes and choose to spend their lives there. Noteworthy is that most of them are illiterate and do not even have much knowledge about HIV/AIDS, but they know that it exists. For most of them, it is a disease that 'just came' and changed their lives for the worst.

### **3.3 DATA COLLECTION**

#### **3.3.1 Selection criteria and sampling**

According to Erikson's psychosocial theory of development, late adulthood spans from 60 years onwards. However, consideration was taken of the work by Gormly and Brodzinsky (1993) which found that how old one feels depends on how long one expects to live. To note are countries where life expectancy is below 45 years, where one will be perceived to be old by the age of 35 years (Gormly & Brodzinsky, 1993). Similarly, in the Zimbabwean scenario, life expectancy for women is 34 years and 37 years for men (UNAIDS, 2006). This had an effect in the way I compiled the selection criteria for the investigation.

In compiling the selection criteria for selecting participants, I considered grandmothers who were from 55 years of age and older and were identified as primary caregivers of one or more grandchildren who were from a month through to 18 years of age, and whose parent or parents had succumbed to AIDS. A primary caregiver was viewed as one who provided instrumental and expressive care to a grandchild or grandchildren living in the same household on a daily basis for an indefinite period of time (Sands & Goldberg-Glen, 2000).

Participants were selected using purposive sampling (Patton, 1990, cited in Merriam & Associates, 2002), which enabled the inclusion of participants who could richly contribute to the investigation of the psychosocial impact on rural grandmothers caring for the grandchildren orphaned by HIV/AIDS. Initially, 15 grandmothers were set to be interviewed, but only 12 were interviewed due to circumstances beyond my control (to be discussed later in the chapter). On the other hand, a small sample size would allow for the development of contextually rich narratives that would deepen an understanding of psychosocial impacts of HIV/AIDS on the grandmothers (Winston, 2003). A further consideration in limiting the sample size was the relative difficulty in locating grandmothers who met the selection process and were willing to discuss very sensitive issues.

According to Black (2002), the main advantage of purposive sampling is that one can possibly better ensure a cross-section of the population in a small sample. When the participants were, eventually, selected, I was convinced that the chosen grandmothers were likely to be able to yield information that was relevant and important to the investigation. However, it should be noted that with this approach, I may not have identified all contributing variables and characteristics, or that individual bias may prevail when carrying out the selection.

Selection of the grandmothers was a collective decision. First, I approached the Social Welfare Department for assistance because of their involvement in social issues affecting the disadvantaged in the country. After repeated visits, I eventually found an official who showed interest to assist me in the identification of some of the participants. It took days to identify eight grandmothers who were registered with the Social Welfare Department and who suited the selection criteria, however, the majority of these grandmothers were not from the geographical area selected for the investigation. Another avenue I took was to locate ward councillors for specific areas and I managed to contact one female councillor who even accompanied me to the identified grandmothers in order to seek their consent. This actually made it easier for me as the councillor had earlier on spoken to the grandmothers, and as a result, all the grandmothers agreed to participate.

On one occasion, with the help of the Sister-in-charge of Mukaro clinic, I met with the Chief of Mukaro Area, along with two headmen of his chiefdom, and he gave me permission to carry out the investigation with the help of the headmen. As a result, the headmen undertook the identification of the participants and I subsequently visited the area on the dates that we had agreed upon for the participants to give their informed consent. Interviews followed at a later stage. I further selected participants with the help of the National AIDS Council (NAC) of Gutu, known at district level as District AIDS Council (DAC). The Council assigned me one of their Home-Based Care (HBC) workers to cover the Utsinda area. She was helpful in assisting me to identify suitable participants for the study as she hails from that area. The demographics of the participants are provided in the next chapter.

The selection of participants was, however, not an easy task because most grandmothers in this rural area are caring for orphans. Some grandmothers even troubled the HBC worker assisting me, asking to be included in the selection process, because these impoverished grandmothers were eager to obtain any form of assistance and had therefore mistaken my research study for charity work. These grandmothers were not aware of the fact that only HIV/AIDS affected households were included, not just households with orphans. Hence it was a difficult matter to explain why some grandmothers were being left out when they were quite certain that they met the criteria for inclusion. At the same time, I had to treat the selected grandmothers' situation confidentially.

Having completed the selection of participants, I needed to approach the selected participants with the help of the people mentioned. The fact that I was being escorted by people familiar to the participants made it easier for the grandmothers to be at ease. Important to note, is the fact that these grandmothers had not gone public with the fact that their child or children passed away because of HIV/AIDS, and therefore broaching the subject of HIV/AIDS caused a degree of discomfort. I needed to keep in mind the fact that in interpretive research, one should not disturb the context unduly, but rather attempt



to become a natural part of the context in which a certain phenomenon occurs (Terre Blanche & Kelly, 1999). Subsequently, I had to achieve this by entering the research setting with the necessary care and engaging with the grandmothers in an open and empathetic manner, given the sensitive nature of the topic. However, the discussions later flowed in the desired direction. The grandmothers welcomed the discussions as they believed that, even if my investigation was solely academic, one day someone would read the research report and come to their rescue.

Having been assisted by the afore-mentioned authorities, my path had been paved in gaining access to the participants and no difficulties were experienced in negotiating the data gathering process with the participants.

### **3.3.2 Data gathering technique**

The investigation made use of open-ended semi-structured interviews, which were in-depth in nature. According to Cunningham (1993, cited in Lewis, 2000) interviews represent important parts of any social research project because it provide the opportunity for the researcher to investigate further, to solve problems, and to gather data, which could not have been obtained in other ways. With these interviews, the goal is to explore a topic more openly and to allow interviewees to express their own opinions and ideas in their own words (Esterberg, 2002). The interviewees' responses shape the order and structure of the interviews. Hence, in-depth interviews are particularly useful for exploring a topic in detail. In the same vein, Terre Blanche and Kelly (1999) state that interviewing gives the researcher the opportunity to engage with participants, so that he or she can obtain a better understanding of how they think and feel.

### **3.3.3 Interview schedule**

With in-depth interviews, Bryman (2001) points to the fact that the researcher compiles a list of questions of fairly specific topics to be covered, often referred to as an interview schedule, but that the interviewee has a great deal of leeway in how to reply. It is crucial,

therefore, that the questioning allow interviewers to hear and understand the ways in which research participants view their social world and that there be flexibility in the conduct of the interviews. The interviewer may ask additional questions based on the participants' responses. To this effect I prepared an interview schedule with the aim to explore more deeply how grandmothers experience caregiving at an advanced age. (See Appendix C).

Participants were asked a series of demographic questions (i.e., age, years of caregiving, and the number of orphaned grandchildren in their care). Questions about family events that precipitated their caregiving responsibilities were also posed, as well as questions relating to how they experienced the role. I also asked participants about their lifestyle changes, issues about survival, coping strategies, and how, in their opinion, the problem of HIV/AIDS is viewed in their societies.

I opted to use open-ended in-depth interviews as a data gathering technique because of its flexibility. This technique allows a researcher to ask new questions that follow up interviewees' replies and to vary the order of questions (Bryman, 2001). Of note as well is the fact that the interviewee may be interviewed on more than one occasion, or sometimes even during several occasions. By and large, the same questions will be asked and similar wording will be used from interviewee to interviewee.

In interpretive research, the researcher is the primary instrument for both collecting and analysing the data (Terre Blanche & Kelly, 1999). Thus, the process of data collection began as I made contacts with the identified participants individually at their own homes. Those who agreed to participate in the study had the contents of the informed consent form explained to them and, after indicating that they understood the process, were requested to sign the form (see Appendix A). Organisations such as the National AIDS Council of Gutu and the Department of Social Welfare, as well as one local clinic (Mukaro) were approached and by signing a counselling service form (see Appendix B) agreed to offer counselling services to participants traumatised by the interviewing.

I also approached non-governmental organisations, which include Rural Unity for Development Organisation (RUDO) and CARE Zimbabwe International. These organisations are concerned with the provision of relief payouts to needy families, as well as of the provision of school fees to orphans. The organisations assist both at community and household levels. I also gathered information from ward councillors concerning the available mechanisms to assist grandmothers and in doing so, I learnt of the existence of a community-based initiative called *Zunde ramambo*. Details on these will be provided in the next chapter.

### **3.3.4 Procedure**

As mentioned previously, entry into the identified villages was gained through assistance from local gatekeepers who included village headmen and ward councillors. The Department of Social Welfare also provided names of those grandmothers registered with them. After access was granted, names of suitable participants were provided. Thereafter, I undertook a selection of the names to suit the selection criteria.

### **3.3.5 Pilot Study**

In order to evaluate the interview schedule a pilot study was conducted. The pilot study was conducted by interviewing two grandmothers from the village of Mukadziwasha. The results of the pilot study indicated that more rapport was needed with the participants. This would have, for example, allowed important information to be gathered if participants had become used to me and developed faith in me. It is important to note that interpretive researchers do not make clear-cut distinctions between the different phases of research, but may reformulate their research questions as a result of new material they have collected, or change their sampling strategy in response to new findings (Terre Blanche & Kelly, 1999). It is to this effect that I carried out the rephrasing of certain questions as well as the inclusion of songs and family trees of participants. Songs provided another avenue for unravelling the emotions and experiences of participants regarding their losses and how they felt about their role as caregivers. Songs

also opened a forum to reveal how grandmothers communicated with God and rested their faith in Him with some accepting their situation, while some questioned it.

Noteworthy is that when I carried out the pilot study, I was sceptical of the outcome of the research. The stories of the two grandmothers as well as their ages differ and this made me realise that I faced a major challenge in the study. As this was my first research study on this scale it actually caused anxiety in me. During the pilot study I observed that these grandmothers preferred the word '*chirwere*' (the disease) in referring to AIDS and so this was addressed in the main interviews. In addition, I realised the importance of songs because they were not sung during the pilot study, which may have caused the interviews to end in a tense atmosphere. The inclusion of songs, on the other hand, may provide a forum to unravel the true emotions which the grandmothers' spoken words could not reveal. It was observed during the main interviews, that the singing of songs was laden with meaning, that is, with expressions of how grandmothers view and feel about their situation.

### **3.3.6 The interviews**

As mentioned, the advantage of using interviews as a research tool is that it is possible for the researcher to listen to the respondents and investigate their thinking firsthand (Winston, 2003). Winston (2003) adds that we interview people to find out from them those things we cannot directly observe. Interviews were conducted in Shona. The central purpose was to engage in dialogue with participants to elicit their descriptions and perceptions of themselves as well as their understandings and experiences of their situation as caregivers. Interviews were open-ended in order to permit and encourage participants' use of their own words in describing their role as caregivers to orphaned grandchildren. Each participant was interviewed separately at her own home. The interviews were carried out usually in the grandmother's kitchen huts and lasted between 45 minutes and one hour. All the interviews were audio-taped and all participants gave consent to this.

The interviews began with a brief reminder of what the topic was about, followed by non-threatening open-ended questions (i.e., When and where were you born, can you tell me about your life?). The aim was to put the participants at ease. Thereafter, further questions were asked, by proceeding from the general to the specific questions according to the planned interview schedule. I made sure that I carried out more listening than talking in order to capture rich information while participants talked about their role as caregivers to orphaned grandchildren under difficult circumstances.

During all the interviews, I made an effort to establish trust, to build rapport and also to make sure that all the questions that were asked related to the focus of the investigation. I demonstrated that I was listening carefully by using verbal and non-verbal clues, while encouraging phrases were employed as well, for example, 'could you elaborate on that one?'. This was done to probe the participants more fully. Conversation was also encouraged through use of body language, for example nodding to indicate active listening and genuine interest in what the respondents were saying.

Capturing my observations in hand written notes supplemented the tape-recorded information. These were meant to help sort out the data as well as to assist in the compilation of the final report. I informed the interviewees when the interview was coming to an end and invited them to ask questions. I also ensured that the interviews led to an open-ended exploratory discussion, inviting participants to tell extended stories about their experiences, which was made possible with the inclusion of various songs. Thus, in conclusion, I asked them to sing their favourite song, which I also used as a tool to explore their thoughts and experiences on parenting orphaned grandchildren.

### **3.4 DATA ANALYSIS**

Interpretive analysis, the method selected for analysing the gathered data, involves reading through the data repeatedly, and engaging in activities of breaking the data down (thematizing and categorising) and building it up again in novel ways (elaborating and interpreting) (Terre Blanche & Kelly, 1999). Here, the researcher should identify themes

and attempt to build up a detailed picture of the experiences of the participants. I therefore began the process of analysis the data by transcribing and translating the audio taped interviews from Shona to English.

As suggested by Terre Blanche and Kelly (1999), I approached the process of analysis by immersing myself into the research material, thereby, reading through texts several times. This was followed by inducing themes, based on the participants' thick descriptions. Coding later followed, where I needed to break up the body of my data into labelled meaningful pieces. The coded material was later clustered under a certain code heading and further analysed both as a cluster as well as in relation to other clusters. At this point certain themes emerged, which would change in the process of coding as my understanding of the themes deepened. Elaboration of the themes later followed as I explored the themes more closely with the purpose of capturing the finer details of meaning, which I might have missed during coding and thematising. Finally, interpretation and checking followed, whereby I put the complete interpretation of the analysed material together. To summarise, I created an outline or coding structure of fixed headings to which all participants' comments on the same topic were grouped. These fixed headings represented the essential topics in the interview schedule. This then became the overall outline for coding and categorising the data.

It is important to note that in qualitative research, data analysis often occurs simultaneous with data collection, as postulated by Merriam and Associates (2002). This means data analysis starts with the first interview, allowing the researcher to make adjustments along the way, even to the point of redirecting data collection, and to test emerging concepts, themes, and categories against subsequent data. The categorised themes emerged from the process of analysis based on the stories of the grandmothers.

### **3.5 CREDIBILITY OF THE METHOD**

According to Bryman (2001), in qualitative research the approach tends to be much less structured, which raises questions of the reliability and validity of the measurement of

key concepts. Bryman (2001) further notes that there is an emphasis on greater generality in the formulation of initial research ideas and on interviewees' own perspectives. Bryman (2001) adds that issues of validity represent a problem for qualitative researchers because of their tendency to employ case studies and small samples. Owing to the nature of qualitative findings where, for example, unstructured interviews are conducted using a small number of individuals in a certain group or locality, it is often impossible to know how the findings can be generalised to other settings. Bryman (2001) concludes by stating that instead, the findings of qualitative research are to be generalised to theory rather than to populations.

The validity of the data collected in this study was addressed through the use of various other sources of information which were used to supplement the interviews. These additional sources included internet and current researches, as well as updated data, for example yearly global reports on the AIDS epidemic by UNAIDS. Direct quotes obtained from field notes and tape recordings of the interviews were also used. Also, only one interviewer conducted all the interviews to reduce the effects of multiple researchers. Reliability was ensured by cross-referral between field notes and tape recordings, and the multiple playing of the tape recordings (Morse, Barret, Mayan, Olson, & Spiers, 2002).

To return to Bryman's (2001) statement that findings of qualitative investigations are to be generalised to theory rather than to populations, that might have been the case in this investigation, since qualitative studies often exhibit a more descriptive nature than quantitative methods, outlining the different ways a qualitative researcher has gone about research or suggesting alternative ways of conducting research analysis based on the writer's own experiences or those of others (Bryman, 2001). However, this would be almost impossible with a large sample. To summarise, the credibility of the findings is supported by the overall approach to the investigation. As researcher, I had a proper understanding of the research context, the interviews allowed the participants to express what they truly experienced, and the analysis of the interpretive process was performed with a continuous reflection on my own involvement, and influence, on the process.

### **3.6 ETHICAL CONSIDERATIONS**

Esterberg (2002) cautions that researchers must ensure that participants freely agree to participate in the investigation, and they must protect the privacy of their research participants. Researchers must also inform participants of all potential risks stemming from participating in the research and gain their consent before beginning.

#### **3.6.1 Informed Consent**

Ethical issues in social research cannot be ignored in that they relate directly to the integrity of a piece of research and of the disciplines that are involved, as maintained by Bryman (2001). For this reason, I ensured that participants were competent to give informed consent, that is, that they were in a sound state of mind to make independent decisions. To this end, they were provided with sufficient information about the study to allow them to decide for or against their participation. No coercion was used in any way. Informed consent forms were given to participants once they had been provided with all the information pertaining to the research and expressed their willingness to participate voluntarily.

#### **3.6.2 Confidentiality**

According to Bryman (2001), the principle of confidentiality falls under the issue of avoidance of harm to participants. This means that identities and records of individuals should be maintained as confidential. I ensured this by adhering to the following:

- Keeping all information (tapes) about participants confidential with the tapes stored in a safe place where no other person other than the researcher could access them.
- By storing the written scripts (for analysis) confidentially, and on completion of the study, intending to destroy them.



- By recording only that personal information which was necessary for the study to achieve its purpose.

It should be appreciated that principles of ethical research conduct overlap somewhat; that is, for example, the principle of informed consent could not be built into an investigation in which research participants were deceived (Bryman, 2001). Subsequently, no deception was used in this research and informed consent was sought prior to the interviews, to which all participants gave consent. It should be noted that identities and records of participants were also maintained as confidential. As mentioned, counselling services were also arranged for with responsible organisations should participants be in need of counselling.

### **3.7 CHAPTER SUMMARY**

The focus of this chapter was placed on the research method. Merits and demerits of the methodology were discussed, while the method of data gathering and analysis were discussed, along with the relevant ethical considerations. In the next chapter, the findings of the research, including the stories of some of the grandmothers, and an outline of the themes that emerged during the data analysis, will be discussed.

## CHAPTER 4

### RESEARCH FINDINGS AND DISCUSSION

#### 4.1 INTRODUCTION

This chapter contains the findings of the investigation of the psychosocial impact of HIV/AIDS on rural grandmothers who care for their orphaned grandchildren. The research findings are presented in two sections, first a biographical profile of the selected participants, and second, a discussion of the themes and sub-themes that emerged from the data analysis. The discussion is supported by extracts from the participants' stories.

#### 4.2 BIOGRAPHICAL PROFILE OF GRANDMOTHER-CAREGIVERS

Table 1 below furnishes the biographical information of the 12 participants, including the number of children they lost, mostly to HIV/AIDS, as well as the number of orphans they care for.

**Table 1.** Biographical information of participants

Grandmother	Age	Marital status	Number of children	Number of deceased children	Number of orphans cared for
Ruva <sup>1</sup>	76	Widow	8	2	4
Rati	Late 60s	Widow	6	3	3
Mugo	65	Married	8	3	9
Harugumi	74	Widow	8	6	5
Norangu	75	Married	10	2	3
Ravirai	56	Married	4	2	5
Shumba	59	Divorced	3	1	5
Ndomusha	64	Widow	7	5	6

<sup>1</sup> These are not the participants' real names.

Chandirega	Early 60s	Divorced	4	1	4
Runenharo	66	Widow	9	5	5
Ndakaziva	56	Widow	4	2	4
Pedzisai	74	Widow	1	1	1

I will now briefly introduce the 12 participants (Note: The participants are introduced in no specific order).

Grandma Ruva is a 76 year old widow whose late husband had three wives, she being the third one. She bore eight children from her marriage, losing two to AIDS, and has a daughter-in-law whose ailing husband's condition deteriorates daily at her house. She cares for four orphaned grandchildren.

Grandma Rati is a widow in her late sixties whose husband married a second wife and dumped her in the rural areas. She has six children, three of whom have died, leaving her with three orphans. Her husband and his second wife later died of AIDS in her care, leaving behind an infected child with her.

Grandma Mugo is a married woman of 65 years whose husband is a cancer patient. They had eight children, three of whom passed away as well as a daughter-in-law. Grandma Mugo cares for nine orphans alongside her ailing husband.

Grandma Harugumi is a 74 year old widow who gave birth to her first child while separated from her husband but later re-united and bore eight children, six of whom passed away. Three of the deaths were confirmed as AIDS related; she cares for five orphans.

Grandma Norangu is a 75 year old married woman who had ten children from her marriage. Two of the children died of AIDS and she now cares for three orphans, with little assistance from her beer-loving husband.

Grandma Ravirai is a 56 year old devoted Catholic who believes that she was destined to care for orphans since she had grown up as an orphan too. She bore four children, two of whom died of AIDS, and a daughter-in law, leaving her with four orphans. Her son-in-law never came to convey condolences after his wife's death, let alone support his children.

Grandma Shumba is a 59 year old divorced woman who bore three children from her marriage. She lost her eldest daughter to AIDS, who died in her care leaving behind two orphans. The younger daughter's husband passed away on 30 July, 2005 and her in-laws asked her to return to her original home along with her three children; all are now under her care.

Grandma Ndomusha is a 64 year old widow who bore eight children. She lost five children but is disheartened by the death of one of her sons who was murdered in South Africa; she never saw his grave. She cares for five orphans and complains that their fathers are not supportive of them. She is a fervent Christian who believes God will one day vindicate her.

Grandma Chandirega is divorced and in her early sixties. She lost one of her three children and cares for four orphans. She brews beer for sale, to raise money for their daily needs.

Grandma Runenharo is a 66 year old widow whose polygamous husband passed away leaving her with nine children. She is a Tuberculosis patient who was beaten and evicted by her step son from the family farm; she left behind all her possessions. The stepson further forcibly inherited her daughter-in law. She lost five children and cares for five orphans.

Grandma Ndakaziva is a 56 year old widow whose late husband married a second wife. She had four children, two of whom died of AIDS, leaving behind three orphans. The fourth orphan she cares for is a stepson, since Mr Ndakaziva and his second wife both

died of AIDS, leaving grandma Ndakaziva in deep poverty; she even tills the ground for cultivation since she possesses no livestock.

Grandma Pedzisai is a 74 year old partially blind widow. She bore one child, a daughter who died of AIDS related illnesses leaving behind a baby girl a few months after birth. The orphan now guides grandma Pedzisai as her sight is now poor. The orphan's maternal grandmother passed away on the day of the interview and grandma Pedzisai and her grandchild were obliged to walk a long distance to attend the funeral.

(See Appendix D for a narrative account of some of the participants.)

### **4.3 EXPERIENCES IN CARING FOR ORPHANED GRANDCHILDREN**

Through the process of interpretive analysis three main themes arose. These themes are: (1) challenges experienced by rural grandmothers in caring for AIDS orphaned grandchildren, (2) grief responses and coping strategies, and (3) support systems available to assist rural grandmother-caregivers in caring for AIDS orphans.

#### **4.3.1 Challenges experienced**

Most participating grandmothers experienced stress relating to the caring of their grandchildren, which specifically included unexpected pressure (for example financial constrains) and transitional problems of becoming primary caregivers (for example child management problems). These stressors impacted directly on the grandmothers' own emotional needs. In this section, the major challenges facing these grandmothers in their caregiving role will be discussed.

##### ***4.3.1.1 Unemployment makes it difficult to provide***

At the time of the interviews, all the participants were unemployed. Their unemployed status made it extremely difficult for these grandmothers to provide for their

grandchildren's basic needs, including the provision of food, soap, clothes, shelter, and school fees. School fees were raised as the main problem, given the ever-rising inflation in the country. Even for primary school children, levies were high, to the extent that most grandmothers had to go out of their way in sourcing the needed funds. Some grandmother-caregivers even went so far as to negotiate with the older orphans in their care to drop out of school and to search for jobs in order to support the family. However, these orphans would not hear of this, as shared by grandma Mugo: *'Since last year, I have been begging her, this one in form three, please drop out of school as you can see this heavy burden I have, but she would cry continuously'*. Poverty proved to be a major challenge in most grandmother households, contributing to grandmothers' struggle to send their grandchildren to school. This is consistent with Nyamukapa and Gregson's (2005) study which found markedly low primary school completion rates among children in Zimbabwe who had lost their parents.

For most grandmother-caregivers' households, given the geographical position of Gutu village, food is another major crisis. Droughts are rampant, thus worsening the grandmothers' predicament. There had been a series of erratic rains during most seasons in the area during the past four years. The main problem reported by participants, was that of delayed rainfall which, when it arrived, destroyed the already wilting crops beyond remedy. Most participants would lament their situation, complaining that the *'sun was too much'* meaning the impact of the drought. Most participating grandmothers had no other means of obtaining funds, except for a few, who sold fruits from their home orchards for a meagre wage. This made the problem of obtaining food in these households a cause for concern. One grandmother reported in tears, *'food, food, my daughter, on the fire is a clay pot half-full of dried mushrooms, Some of the orphans do not like them, yet all of them look up to me, it is painful to see them sitting on that bench with dry mouths'*.

#### ***4.3.1.2 Difficulties in accessing governmental aid***

The interviews further reveal that all of the grandmothers complained about lack of access to governmental aid. For most of these grandmothers, ignorance was a major problem. Some grandmothers were not even aware of the existence of governmental assistance that can be obtained through social welfare. This ignorance seemed to be because of the lack of dissemination of information to these elderly caregivers. Many of them did not possess radios let alone televisions and for those who knew about the availability of governmental assistance, nepotism hindered them. The latter complained that the officials responsible for the disseminating of these funds, often put their own relatives first, even those not eligible for funding. This was best described by grandma Mugo when she said *'ah! My child, whenever the government is involved in assisting people, nepotism is the main problem, if you do not know someone there, then you die suffering'*.

In addition to the above, a further problem related to delays in accessing governmental aid for those who were enlisted. Some participants hinted that they would spend days visiting the Social Welfare offices in vain, only to be told that their funds had not yet been cleared, or simply, that their file had gone missing. The repeated visits ended up depleting the little bus fare they had, often forcing them to give up. For those with missing files, no clear explanation was provided, and most probably, because of a lack of knowledge regarding legal procedures to challenge the situation, most grandmothers would not take any further action.

Another problem experienced by these grandmothers was that of a lack of birth certificates for the orphaned grandchildren. Grandmothers often find it difficult to register the orphans for assistance without such crucial certificates, and, obtaining a birth certificate when no such documents were available, entailed finding some witnesses to prove a biological connection with the orphans. To make matters even worst, in most cases, contact had been lost with the orphans' father after the death of his wife. Often, as

explained by the participants, there was no contact between the in-laws after parental deaths.

For some participants, it meant going to Masvingo, the service town in the province, which again entailed incurring bus fare costs, while long queues characterised the situation at the registration offices. Therefore, in the event that one had no relative in Masvingo, he or she would be forced to sleep outside the offices for days, waiting to be served as well as to beat the long queues. Staying away from home also meant buying food despite the poverty-stricken nature of these grandmothers. Furthermore, the grandmothers were often obliged to take the orphans along, which worsen their situation.

#### ***4.3.1.3 Physical constrains***

Most grandmother-caregivers reported experiencing health problems, either from re-parenting at an old age or because of the stress suffered as a result of losing a child or children to HIV/AIDS. This is consistent with Olshevski et al.'s (1999) finding that, owing to the stress of caregiving, elderly grandmothers may enter higher health risk categories than those dictated by age alone. Two of the participants suffered from Tuberculosis and were receiving the necessary treatment. One of them had previously been struck by Herpes Simplex. Grandma Rati's revealed how the participants' health might be compromised when they care for orphaned grandchildren: *'your whole body aches, you cannot tell where exactly, but when you sleep you groan'*. This highlighted physical exhaustion as a challenge among grandmother-caregivers as the capacity of their bodies is now reduced.

Other complaints relating to physical constraints included the experience of pain in the side due to the hard work in catering for the orphans' needs, while for some, visual and hearing impairments were of the highest concern. Two of the participants had difficulty in hearing and so, during the interviews, I had to raise my voice in order for them to comprehend what I was saying. As mentioned earlier, one participant was reliant on her orphaned grandchild, without whose assistance she would not be able to cope since her



vision was too impaired. On the day of our interview, this grandmother had received word that the paternal grandmother of her orphaned grandchild had passed away. This meant that she was now the only surviving grandparent left to care for her grandchild, who was, at that stage, only a primary schoolgirl. Furthermore, because of the lack of financial funds, the grandmother, together with her grandchild, had to walk a distance of nearly 20 kilometres to attend the funeral.

Another health complaint raised by participants was that of painful legs and backache. These pains greatly reduced their capacity in fending for the orphans, as most of the work in the rural areas is manual and routinely done. Of concern was that these grandmothers are usually the only ones left in the families, with no, or very little, assistance from other family members. What seemed to emerge from the interviews was that, despite being the only ones left to fend for the orphans, along with their health problems, these grandmothers, nevertheless, had to find ways to look for a decent income for their households. As mentioned earlier, all of the participants were unemployed and, often, had to depend on their late adult children for assistance. Participants also found that their remaining children had to focus their attention on their own nuclear families. The majority of participants, therefore, found themselves providing labour in exchange for food or money.

For those grandmothers who lived close to the Mpandawana growth point, vending was another option. However, their hopes for earning necessary funds were shattered by the clean up campaign (operation Murambatsvina), which was marked by forceful removal of illegal structures, including unregistered markets. These grandmothers found themselves in a position where they could no longer sell their goods in places that they were used to do, but were now obliged to travel to a demarcated registered market place where they were also required to pay the council for the service. Most of the grandmothers could not afford this, and in addition, residents of the growth point already occupied the more strategic positions for selling their products.

#### ***4.3.1.4 Lack of support from extended families***

The majority of maternal grandmothers were confronted by a lack of support from the extended families of the orphans who they were taking care of. As grandma Ravirai stated: *'We haven't heard from him [the father of the orphans] and his family, they did not even come to convey their condolences when my daughter died and now rumour says that he is on the death bed'*. The lack of contact between the two families often left the grandmothers with no one to look up to for assistance. To worsen matters, the whereabouts of some of the orphans' fathers were not even known. This rather aggravated the grandmothers' situations as they had no one to turn to in times of crises, for instance in obtaining birth certificates of the orphans.

Another problem faced by the participants was that of loss of contact with their remaining children who are living in towns. Grandma Rati, for example, mentioned that her children who reside in Harare did not even visit her in the rural area where she resided. People told her that some of her children were married and she hadn't even met their wives or husbands, let alone her grandchildren. She also stated that one of her sons only returned to the rural area as an ailing patient whose wife simply posted him on the bus to the rural area while she stayed behind in Harare. The son later died in the care of the grandmother, while she was also caring for other orphans.

Participating grandmothers who indicated that they received assistance from the extended families stated that it was mainly from their families of origin. Their blood brothers and sisters were usually the ones who helped in times of crises. Ironically, the families they were married into were less likely to provide assistance. However, for some grandmothers who grew up as orphans, the situation was rather difficult, as they were forced to fight a lone battle. This, again, raised questions regarding the role of the extended family in the wake of HIV/AIDS, and relates to the findings of Foster (2000), who noted that it is clear that in AIDS-affected communities throughout Africa, the potential for extended families to provide care for orphans is being eroded.

Another challenge faced by the grandmothers is that of acclimatising the orphans to rural life. For most participants, it remained a big challenge to introduce orphans, who grew up in the urban areas, to rural life. Grandma Mugo asked, *'How will I care for them, these ones cannot sleep on the floor and can't do without warm clothing, uugh! What shall I do?'*. Therefore, in such instances, grandmothers found it especially difficult to cope with their role as caregivers. Participants stated that some of these orphaned grandchildren found it hard to perform physical chores such as fetching water, firewood, cultivation, and herding cattle. These chores often involve the need for much physical strength and for some, it means travelling long distances. The grandmothers, however, had to ensure that their grandchildren acclimatised to their new circumstances.

In line with the abovementioned challenges regarding the acclimatisation of the grandchildren, grandmothers were also challenged to acquire meals that these children were used to. Most of the orphans were used to eating fresh food in the towns of origin. They would obtain fresh water from taps and meat was more available. Hence the idea of dried vegetables and no meat on a daily basis is foreign to most of them. The change in environment, especially schools, adversely affects the children, as they must now travel long distances to school. As a result, the grandmothers often had to escort the children to school, especially in the beginning, to ensure that they reach the schools. Some children found it very difficult, they cry, citing exhaustion, which then evoked painful emotions in the grandmothers, wishing their children were alive to lessen their burdens.

Being in polygamous marriages also affected some grandmothers in their care for their orphaned grandchildren. Three of the participants indicated that they had been in polygamous marriages, and found themselves in the position of caring for their stepchildren's orphans. One of the participants indicated that she had to care for her dying husband and his second wife, as well as their last-born child who was infected and later died, following the parents' death. The participant said, rather ironically, that the husband had abandoned her in favour of his second wife and only returned to be cared for by her (the participant) in the rural area he had once shunned.

#### ***4.3.1.5 Risk of being infected***

Since most of the participating grandmothers had to care for their terminally ill children, they raised concerns about the possibility of themselves being infected with HIV. In addition, some of the grandchildren in their care were infected. The idea of putting on gloves as a safety measure is something that was not understood or acceptable to most of these grandmothers. These precaution measures were viewed as a sign of shunning or discriminating against the sick members of society. Further, even if these grandmothers accepted the implementation of these precaution measures, gloves were not easily available in the rural areas, and, when it were available, it was perceived as too expensive for everyday use.

Even in cases where grandmothers were not sure of the child or children's HIV status, having these children tested was usually perceived as unacceptable, or even impossible, given their rural situation. A further obstacle experienced by grandmothers, refer to the limitation or absence of medication for HIV related diseases, and, when these medications are available, it is often extremely expensive.

#### ***4.3.1.6 Depletion of resources***

Depletion of resources was also a major problem faced by these grandmothers. Most of the food available in the rural areas is dried and scarce, though HIV positive people need fresh products and meat instead of dried vegetables. As grandma Ndomusha stated, *'This homestead is now quiet, all my chickens are now gone'*. Few of the grandmothers possessed livestock and so most of the households were poverty stricken in nature. Therefore, caring for their ill children rather worsened their situation and the subsequent care of their orphaned grandchildren also made things worse. As noted previously, drought worsens the legacy.

Additionally, and as noted by Matshalaga (2004), one of the biggest identified problems, besides sanitation requirements in rural areas, is the dietary needs of HIV patients. When

these patients are discharged from hospital, a special diet is usually recommended, which usually consists of a list of preferred food items whose nutritional value, according to the hospital staff, will assist the patient in the recovering process. The problem, however, is that most of these food items are out of reach of the grandmother-caregivers and are often not available. This led to depletion of resources as most grandmothers complained that most of the ill patients preferred to continue with their urban-based diets which were neither available nor affordable in a rural setting. Most of these patients preferred meat, eggs, fresh vegetables and cool drinks. To that end, most households sold their livestock in order to meet these demands in the belief that they should respect the wishes of the terminally ill person as there are cultural fears that, if they are disgruntled, their spirits may wreak revenge after death. Thus, HIV/AIDS is a major cause of deepening poverty, as the disease has been indicated to accelerate poverty in most grandmother households.

#### ***4.3.1.7 Hope of a positive life progression recedes***

Joslin and Brouard (1995) found that, as grandmothers take over the care of their surviving grandchildren, these newly found families are placed under enormous stress. This is in stark contrast to the expected life progression of grandparents to enhanced status and prosperity as a result of advanced age. Given the stress associated with caregiving in late life, and the greater risk of poor health among the rural elderly, the older grandmother-caregivers in these communities represent a potentially high health risk population whose own needs may go unrecognised and unattended (Joslin & Brouard, 1995). This was found to be true of the grandmothers in the present investigation, as there was little mention of them seeking medical care for themselves, except for those on Tuberculosis medication which was free. For these grandmothers, however, it was the health of the grandchildren that came first. This situation was worsened by the young ages of the children in their care, which may suggest that many of these grandmothers may continue to be caregivers as they reach their late adulthood. Hope of a positive life progression, therefore, receded as these grandmothers despair about their situation.

Compounding the psychological stress experienced by rural grandmother-caregivers is the profound stigma surrounding HIV/AIDS in their communities. According to these grandmothers, there was a veil of secrecy about the disease and a degree of shunning of the affected families, and, while everybody might know about the disease, nobody seemed to talk about it publicly with the families affected. This only aggravated the situation of these grandmother-caregivers, as they knew how their households were portrayed in society. At the same time, some grandmothers were facing additional stress associated with raising children who have special health and psychological needs, as indicated by Grandma Mugo: *'And this handicapped girl, how will I raise her, what will I give her?'*

As indicated by other studies (Joslin & Brouard, 1995; Joslin & Harrison, 2002; Matshalaga, 2004), the present investigation revealed that grandmothers experienced diminished physical and emotional health following the initial process of becoming caregivers. Moreover, the physical, emotional, and financial stressors associated with caregiving might have exacerbated chronic health conditions such as diabetes, hypertension, and cardiovascular disease. As in the case of Joslin and Harrison's (2002) study, this investigation also found that the stress related to the raising of HIV-affected and orphaned grandchildren might have precipitated or aggravated chronic conditions in most grandmothers. These findings are supported by Erikson et al. (1986), who claimed that indeed, during old age, there is much sorrow to cope with, thus some despair must be acknowledged and integrated as a component of old age, and, worse off for these caregivers who are confronted with various pressures.

#### ***4.3.1.8 Increased uncertainty about the future***

The most stressful aspect of caregiving, according to participants, was the increased uncertainty about the future. A common statement raised by various participants was *'I do not know what will happen to these orphans if I die'*. For many, there was no contingency plan and therefore they kept on worrying. The fear of an uncertain future took on an added intensity because most grandmothers were socially isolated and, often,

had no one to confide in or who could share their predicaments. This caused them to believe that this caregiving role at an advanced age, and under difficult circumstances, would send them to an early grave, but not as early as that of their children. Clearly, there was neither active anticipation of dying nor any meaningful planning, which according to Erikson (1982), hints as attributes of old age.

#### ***4.3.1.9 Psychological predicaments and emotional stressors***

Similarly to the findings by Mayer (2000), this investigation found that the challenges and struggles that grandmothers, caring for orphaned grandchildren, face are extensive and often involve psychological predicaments and emotional stressors. Many of the participating grandmothers faced on-going psychosocial issues relating to the basic physical, emotional, and financial adjustments they must make. They often had to endure emotional reactions such as shame, guilty, anger, self-doubt, and dissatisfaction with their parental role. Most of these grandmothers found themselves being confronted with a double edged sword as they questioned their competency, while some reported a sense of failure at how they raised their own children. In their current situation, they begun questioning their own competency, while they were also faced with the reality of their aging, which, combined with the difficulties associated with raising a grandchild, further gave rise to heightened concerns about health problems.

Consistent with Joslin and Brouard's (1995) findings, this investigation also established that these older grandmothers who were raising grandchildren, had to contend with unique strains imposed by HIV diagnosis and progression. These strains arose from HIV stigma and isolation, while the grandmothers, simultaneously, experienced the physical and emotional demands of caring for an infected, ill or dying child, while grieving over losing their adult child or children to AIDS. This investigation found that, in these rural communities, it was common that most grandmothers were mourning the deaths of several adult children, which meant taking on the responsibility of caring for many grandchildren as well. Of note is that these grandmothers' plight was worsened by the fact that they found themselves withdrawn and isolated from traditional social support

systems because of the AIDS stigma. Therefore, they might have been reluctant to seek assistance for themselves or their families.

For some grandmothers, seasons or events and special occasions brought back sad memories, as well as feelings of regret and loss, which further added to the already mentioned stress. Grandma Mugo, for example, said that Christmas reminded her of the sad loss of her son, which was followed by the subsequent death of her daughter-in-law the following Easter.

Most grandmothers reported that they seek meaning in the traumatic experiences they have had, and it was observed during the interviews that they spoke with deep feeling and passion about their role as caregivers, despite the difficulties. Most of the grandmothers cited difficulty in revealing to their grandchildren that their parent or parents had died of AIDS, often because these grandmothers themselves experienced difficulty accepting it. To add, each new developmental stage for their grandchildren and each shift in their own life course signalled radical changes in their lives. It is important to note that these grandmothers and grandchildren differed in their coping styles and abilities, and as such, children of different ages called upon different resources. Mayer (2002) expresses similar sentiments by noting that severe reactions are therefore likely to occur in those cases where young children are not given an explanation regarding the disappearance of their parents.

The circumstances faced by these grandmothers caring for their grandchildren are complicated and stressful, as also noted by Waldrop and Weber (2001). These grandmothers might have looked forward to middle and late adulthood as a relaxed period of their lives, however, this expectation was altered as they were forced to adapt to a new rather troubled situation, which required that they offer stability and security to their grandchildren. These grandmothers are experiencing what Erikson et al. (1986) referred to about old age as a time when life brings many, quite realistic reasons for experiencing despair. Notably are, aspects of the present that cause unremitting pain, and aspects of the future that are uncertain and frightening.



### **4.3.2 Grief responses and coping strategies**

#### ***4.3.2.1 Grieving for a deceased child***

*'Each morning revives sad memories and the reality of your losses and burdens, and to face the poor orphans, how emotionally draining it is.'* This quotation by a participant best described the extent to which a bereaved mother can go in terms of grieving for a deceased child and it was found to be a common scene in most households. In this regard, religion plays an important role in rural areas and can be a significant source of support for the family (Myers et al., 2002). Most grandmothers echoed the view that their religious affiliation was a source of consolation. For some, meeting other people in the same situation gave them the assurance that they were not alone in this battle. These grandmothers prayed every time they felt the burden to be too heavy. They believed that God had put them in the situation for a purpose and that He had taken away their children for a reason and, therefore, that they should accept it and move on.

It is all-important to note that most grandmothers were religious in nature and believed that AIDS was *'that incurable disease foretold in the Bible'*. Hence, in a way, they thought that it was a punishment from God for bad behaviour and that they could not question the deaths of their children but rather accepted it as God's will. In addition, for those grandmothers who grew up as orphans, there was the belief that their destiny had been predicted before the time their parents died, and the pattern continued as they rear orphans themselves. Thus, religion and spiritual life formed an important source of personal strength for these grandmothers.

#### ***4.3.2.2 Despair and grief***

One grandmother remarked, *'If it was possible, I would sit on his grave and ask him why he left these orphans to suffer with me'*. These words can best describe how grandma Ravirai felt at the time of the interview, even if her son had died in 1994, and his wife in 2005. For grandma Mugo, it was even worse because, upon entering her gate, she would

began sobbing since asking her questions about her late children opened up her wounds afresh. This actually made my research journey difficult as I evoked sorrowful emotions in some grandmothers by treading upon sensitive areas of their lives. Grandma Mugo lamented the deaths of her children and stated that every time the orphans return from school, tears roll down her cheeks, wondering why their parents died leaving the children to struggle in her care.

For some participants, days just came and went by, with no answers to their unending questions. The main question raised by participants referred to why their children had died before them? It is important to note that the situation in the country, resulting in political and economic instability, droughts, and inflation, exacerbated their plight. Most grandmothers lamented the idea that there was a great likelihood that no one will take care of the orphans once they pass on. For most of them, life will never be the same again. Erikson et al. (1986) remarked that in late adulthood, there remains inescapable death, that one aspect of the future which is both wholly certain and wholly unknowable. Grandmothers in this investigation found themselves worrying about uncertainty regarding the future of the orphans in their care as well as their own immortality.

Most grandmothers complained that their problems were not viewed as those of society. Integrity, as defined by Erikson et al. (1986), was therefore difficult to achieve since these grandmothers reported a strong tendency amongst other villagers to view their households as well deserving their situation. This reaction of other villages might have been the case because these grandmothers' deceased children often had good jobs in town and had seldom, or never, visited the rural areas, except when they were on their deathbed. Thus other villagers often showed little or no empathy for the grandmothers, on the, often false, assumption that they had once received goods from their deceased children. According to the participants, there was also the assumption amongst villagers that the late children well-deserved their illnesses as they were presumed to have been promiscuous in the urban areas.

It is not surprising that in the era of HIV/AIDS, in the event of subsequent deaths, people still search for answers in the traditional way. It was reported that in some households, relatives and neighbours interpreted the multiple misfortunes experienced by grandmothers as *ngozi*, a Shona word for the spirit of vengeance. This was reported as a common theme in well-off families since it was assumed that for the children to be well off they should have killed someone for ritual purposes, and now the tables were turned. Such issues only aggravated the plight of some grandmothers because their own society was not receptive, thus adding on to their grief. In the next section, some of the grandmothers' stories will be told.

#### ***4.3.2.3 Spirituality***

For most grandmothers, prayer, song, and faith were resources assisting in the care of their dying children as well as the remaining orphans. They prayed to God, bargaining with Him to heal their ailing children, and if this failed, they went on to pray for strength to care for the orphans. Therefore, praying and attending church helped some of these grandmothers to cope with the challenging demands of parenting at an advanced age, while simultaneously grieving the loss of a child. A common religious song was sung by most grandmothers as a way of coping when in distress. Its words are:

*Receive Oh! Lord, all my heart, my thoughts, my desires,  
And my possessions. For it is you who gave me all that I have  
I willingly render you back. May your will be done Lord.  
For you saw it befitting, let your will be done.*

The song seemed to represent the grandmothers' way of letting God take control since they accepted that the deaths were God's will and therefore no one could have challenged it. Most grandmothers displayed grief as they sang with tears rolling down their cheeks, which actually drove me into the same situation since the atmosphere became so emotional.

As mentioned earlier, the people of Gutu village are largely of Shona origin. The influence of Christianity is extensive and pervasive and has greatly influenced their beliefs. Most of the interviews were conducted on Sundays so as to reach the grandmothers together with their grandchildren and I made certain that I did not compromise their church timetable. As observed by Berger (1994), I also found that these older grandmothers are more spiritual than during the earlier stages of their lives. This is witnessed by the election of numerous older people as 'elders' of the church, for example, Berger (1994) point to the fact that more popes have been elected in their 80s than in any other decade of their lives. There is, therefore, a confirmation of a general increase in religious faith, prayer, and spirituality in later years, which according to Erikson et al. (1986), is due to the realisation of the futility and pettiness of human life.

Noteworthy, though, is the fact that the participating grandmothers still believed in their ancestral spirits. For instance, they believed that if someone loses children in succession, or if they die after a long illness, then the ancestors may be angry with them, probably for wrongdoing. This is manifested in some rituals performed after burial, for example *kurova guva*, which is a ritual meant to hand over the deceased's spirit to the ancestors in return for being watched over by the same ancestors here on earth. Hence, in a way, their grief is worsened by haunting thoughts of being in a dilemma, wondering who had done wrong, they themselves or their children?

However, not all grandmothers found solace by going to church. For grandma Harugumi, her faith had been shaken, following her losses. She said, *'It is a lie which they tell us that if you pray using the rosary you will be healed'*. To her, religion failed to heal her broken soul following the loss of her six sons. Consequently for her, drinking beer is the solution, since she praised it for helping her to forget her problems and she therefore managed to sleep peacefully without disturbing thoughts regarding the deceased. Another grandmother, grandma Ruva, had never been to church since the death of her daughter-in-law in 2004, the reason being that she could not stand the idea of looking at the empty place which her daughter-in-law used to occupy in church. These findings may suggest a

coping mechanism of avoidance, since these grandmothers did not want to be reminded of their sad losses.

### **4.3.3 Available support systems**

As indicated by previous investigations (see Matshalaga, 2004; Winston, 2006), a growing concern raised by participating grandmothers was how to meet the financial needs of the children in their care. This responsibility became overwhelming if there was more than one grandchild to rear. These grandmothers indicated a need for education and assistance in identifying additional sources of income. Given the personal toll that accompanies grandparenting, many grandmothers reported a need for support and interventions tailored to their unique needs.

#### ***4.3.3.1 National AIDS Council***

The National AIDS Council assists grandmothers at district level (District AIDS Council-DAC) by offering counselling as well as provision of Home-Based Care (HBC) to those households with ailing patients. The DAC also assists widowers in the same situation. According to participants, this is a much appreciated service since most hospitals are referring patients for HBC, owing to a lack of medicine as well as the overwhelming numbers of ill patients.

#### ***4.3.3.2 Social Welfare***

The Department of Social Welfare assists grandmother-caregivers with the provision of school fees for the AIDS orphans. The beneficiaries are registered with the department and attend school while the department pays for their fees. However, owing to the delays in such payments, participants reported that school heads end up sending the orphans away. According to Grandma Mugo, two primary school pupils in her care were not attending school, having been sent away since their fees had not been paid for a period of

a year. Because of the difficulties experienced in gaining access to funds, participants became reluctant to seek assistance. According to Winston (2006), another reason as to why grandmothers may be reluctant to seek formal assistance is the legacy of mistrust towards most governmental institutions that have been perceived as unsympathetic or deliberately destructive.

The Department of Social Welfare also assists infected orphans with access to medication. These orphans and their caregivers are given certified letters to present to the hospitals or clinics to obtain medication after which the Department pays the medical bills. However, as noted by Matshalaga (2004), the problem with most governmental institutions is the unsympathetic and bureaucratic approach adopted, which makes the process extremely difficult and sometimes even impossible. Another problem cited by the grandmothers, as mentioned earlier, was that of nepotism.

In 2000, the Zimbabwean government introduced the Basic Education Assistance Module (BEAM) to provide financial assistance for education to children in disadvantaged households. However, as noted by Matshalaga (2004), BEAM reaches only a small proportion of vulnerable families and children. Matshalaga (2004) also notes that in times of drought, government offers food relief for poor rural communities, by supplying grain according to the degree of need in each family. But, as Matshalaga (2004) adds, this relief, though helpful, is an unreliable source of food, as food distribution is not always regular enough to keep up with the needs of families.

*Zunde ramambo* refers to a collective field, in traditional Shona society placed under the responsibility of the chief. According to participants, community members took turns to work in this common field at the chief's home. The harvest was used to feed the sick, soldiers, and those arriving to be tried at the courts, all of whom were the chief's responsibility (UNICEF, 1998). This traditional practice is now being resuscitated in the context of orphan care to provide food, the excess being sold to provide other needs like clothing (UNICEF, 1998). However, as Matshalaga (2004) observes, most of these programmes operate within environments of severe poverty and are only able to support a

limited number of the needy orphans. Of note is that not even a single grandmother in the present study indicated that they have been receiving aid from *zunde ramambo*. Possibly, this was because of their reluctance to seek assistance owing to the AIDS stigma.

#### ***4.3.3.3 Non-governmental organisations: CARE International Zimbabwe***

Non-Governmental Organisations (NGOs) have been playing a crucial role in assisting disadvantaged communities in Zimbabwe. Noteworthy is the role played by CARE in the country. Not only does it help grandmother-caregivers, but it also assists poor people, mostly in rural areas, through the provision of food, for example, cooking oil, beans, barley, and so forth. If it had not been for this organisation, many participating grandmothers said that they would have starved in times of drought. One grandmother remarked that, *'if it was not for CARE, many of us would not have made it through to this day.'* Through CARE's field officers, food is dispatched to rural areas and is provided according to the number of occupants of each household. However, grandma Mugo complained that she was surprised when she went to collect her share, only to be told that the family name had been struck off the roll, receiving no clear explanation. To add insult to injury, on top of the eight orphans she cares for, her husband is an ailing patient, needing her care too.

One other NGO is called Rural Unity for Development Organisation (RUDO). It is mainly concerned with education assistance and food security, both at household and community level. The programme concerns orphan and vulnerable children care, which involves direct fees payment and covers many wards in Gutu district. However, as Matshalaga (2004) notes, one of the challenges most NGOs in rural areas face has been to strike a balance between assisting poor communities and at the same time making them more self-sufficient, so that in the event of such NGOs withdrawing, the communities could continue with the development projects. On the other hand, poverty in these communities erodes efforts towards self-sufficiency.

#### 4.4 CONCLUDING REMARKS

Exploring the psychosocial impact on rural grandmothers caring for their grandchildren orphaned by HIV/AIDS gave me a deeper understanding and appreciation of the many obstacles and challenges that most of these grandmothers must confront and overcome on a daily basis. Despite the losses and the hardships they encounter, Winston (2003) hints that an AIDS death carries a stigma that includes shame, guilt, and anger in the surviving family members, a stigma that is often transferred to persons related to or closely associated with the deceased. Yet grandmothers are expected to cope and care for their orphaned grandchildren in such circumstances. Their hopes in late adulthood of being looked after by their adult children are reversed as they again, in the absence of their adult children, take on the role of parents. It also became apparent that most of these grandmothers are receiving limited assistance and little to no social and familial support. Neither their extended families nor the community give the grandmothers their much needed economic, social, and psychological assistance in the care of orphans. However, such forms of support for this group seem imperative as this parenting population continues to grow within our society.

Most grandmothers' experiences of bereavement and grief differed and so did their coping mechanisms. For most grandmothers, their wounds were still fresh, as manifested by sobbing during the interviews. The findings of my study are thus consistent with those of other research (see Matshalaga, 2004; Winston, 2006), except for some inconsistencies regarding coping strategies, which include avoidance and weakening of spirituality among a few grandmothers. The latter has been established to be a strong factor for most grandmothers under these circumstances (Myers et al., 2002). One grandmother highlighted how she found comfort in drinking beer so as to forget her sad losses, while grandma Ruva avoided going to church, as this would bring back sad memories of her late daughter-in-law.



The participants described their reactions and feelings about their children's deaths as devastating and catastrophic. Role strain and psychological distress in a society that stigmatises them aggravates their situation. This finding is consistent with the work of Joslin and Harrison (2002) who found that the implications of diminished health are serious because the grandmothers' parenting capacity may be jeopardised and their own functional independence compromised as they continue to age. Consequently the greater majority of the caregivers are despairing over the sudden turn of events in their lives. Thus successful aging is compromised, as they have to face the crises of re-parenting under especially difficult circumstances. Yet, according to developmental theories, older adulthood should be a time for reflection when one relinquishes previous roles and strives to achieve integrity (Erikson, 1982).

The reported findings have important implications for the older adults living in rural communities caring for orphaned grandchildren, and for the community social service agencies which are supposed to serve this population. These elderly adults find caregiving particularly stressful because they themselves are vulnerable to health problems, while some have lost spouses and are carrying out the role in especially difficult circumstances. They are witnessing a breakdown in their family system and are left helpless as their children die in their prime. Hence this study demonstrated a need to assist these caregivers with insight into how to handle the problems they encounter. Grandmother-caregivers are a growing population due to the ever increasing AIDS related deaths in these communities and thus action is vital. Because not all grandmothers were interviewed, there are actually more than the recorded number of grandmothers who are caregivers to their orphaned grandchildren. And for these grandmothers who are often struggling with their own age-related changes, these demands can often seem overwhelming, especially in rural areas which usually have limited resources for the families. Yet a gap exists in the knowledge base as treatment and research mostly focus on the young, ignoring these new caregivers.

Most of what is reported in the findings seems to appear negative as many grandmothers reported feelings of isolation, powerlessness over their situation and with social support

systems. However, some participants' experiences were positive in nature, as some of these grandmothers still hold on to their faith and find comfort in spirituality and spiritual practices. In view of the above, most grandmothers are despairing as Erikson et al. (1986) remark that despair haunts late adulthood as losses of physical ability are imminent, independence and control are challenged, self-esteem and confidence weakened. Therefore, a combination of these and the loss of adult children, and subsequent care for grandchildren, indeed bring about many quite realistic reasons for experiencing despair. Notably, are aspects of the present that cause unremitting pain, aspects of the future that are uncertain and frightening, and there remains inescapable death, that one aspect of the future which is both wholly uncertain and wholly unknowable (Erikson et al. (1986).

#### **4.5 CHAPTER SUMMARY**

In this chapter the findings of the study were reported, interpreted, and discussed. The study has revealed that grandmother-caregivers experience psychological distress as they re-parent at an older age, in a stigmatising society, all of which leads to role strain in their role as caregivers. In the next chapter, conclusions, limitations of the study, and recommendations will be presented.

## **CHAPTER 5 CONCLUSION**

### **5.1 INTRODUCTION**

In this chapter a summary of observation of the investigation is provided, there after the limitations of the investigation and suggestions for future research, and recommendations for intervention strategies are discussed. The chapter concludes with a reflection of my research journey.

### **5.2 SUMMARY OF OBSERVATIONS**

The research findings discussed in chapter 4 constitute the experiences of elderly grandmother-caregivers in relation to the care of AIDS orphans. Based on these findings, the following observations can be made:

- Although the elderly grandmothers are caring for orphaned grandchildren under difficult circumstances, they are committed to the caregiving role despite the hardships they are encountering.
- Extended family and community members are always very supportive of orphan care; and often, although not on a regular basis, only families of origin offer assistance.
- Although government and non-governmental organisations have set up programmes to specifically address the care of orphans, these programmes do not adequately meet the challenges, while aid is sometimes mischannelled.
- Both the grandmother-caregivers and the orphans in their care are still in the process of mourning the losses experienced, yet they receive little or no social support. Grandmothers are worried about the future of orphaned grandchildren, yet there are no contingency plans for most households.
- Grandmothers have either started to experience ill health due to the death of their children or their health has deteriorated due to this loss and the subsequent care of

orphans. Noteworthy though, is the fact that most of these grandmothers have little, and often no, knowledge about AIDS due to illiteracy.

### **5.3 RECOMMENDATIONS FOR INTERVENTION STRATEGIES**

Based on the observations listed above, the following recommendations regarding intervention strategies are made:

#### **5.3.1 Bereavement counselling**

It is recommended that counselling be offered to elderly grandmother-caregivers and AIDS orphans to assist with their feelings of bereavement and their sense of loss, and also for the grandmothers to understand what they are going through as most of them do not have knowledge about HIV/AIDS. Bereavement according to UNICEF (2002) refers to a sense of loss and the grief and mourning processes that accompany it. Counselling will be necessary to avert their situation and provide grandmothers with the emotional base to face their new realities and be able to care even for bereaved grandchildren.

It is also recommended that there be proper HIV/AIDS awareness at community level to avoid stigmatisation of affected families, so that the community is receptive of caregivers. Trauma counselling following the deaths of their children is necessary, as it is clear that grandmothers need assistance in dealing with the stress of their unexpected and assumed status. Thus interventions should be made at community level so that they feel less alienated and more capable of coping with the demands of parenting the second time around. Despite the need for counselling, it should be considered that not all villages have HBC workers and training and dispatching them to different rural areas can take time.

#### **5.3.2 Skills training**

There is a need to provide grandmother-caregivers with more knowledge, skills training and orientation in raising orphaned grandchildren as they may not be equipped enough to

meet the orphans' requirements as well as those of their ailing infected adult children. For example, they need the following skills: counselling skills to deal with children under stressful circumstances, home-based care and knowledge of HIV/AIDS regarding how to prevent infection and to realise that they themselves are at risk.

The findings of this investigation established that many of the grandmother-caregivers have low levels of education and are only marginally literate. This situation makes it difficult to support the educational needs of their grandchildren, let alone their health needs when they become ill. Therefore, interventions may assist grandmothers to obtain additional support where necessary.

Formal health education and awareness campaigns should be designed for grandmother-caregivers since the plight of old people affected by AIDS has long been ignored. This is because AIDS research and treatment is often focussed on younger generations. Again though, health personnel are few in the rural areas and given that homesteads are spread apart in the villages, this could constitute a difficulty.

### **5.3.3 Social support**

Social support, especially from the extended family, is needed to keep the grandmothers functioning in their care of orphans. This would open up a forum for strengthening the grandmothers with respect to discussing contingency plans in the event of death. Such a topic is usually avoided in their communities. There should be such talk to ensure a brighter future for the orphans.

Social support of these older caregivers is vital not only to strengthen their capacity to continue as caregivers but also to ensure optimal functioning for the future of the grandchildren in their care. Church-based initiatives regarding efforts to support affected households must be developed for the majority of grandmothers who value spiritual healing.

#### **5.3.4 Provision of basic needs**

It is recommended that there be consistency in the dates of delivery of rations by aid agencies. This is important because if the caregivers have not collected food rations on certain days, the orphans' lives will be at stake since the caregivers usually fight a lone battle with no one else to assist them. They may not hear about changes in delivery dates, as they do not have access to the media.

It is necessary that aid agencies spread their coverage to the rural areas, as it is costly for caregivers to travel in order to obtain assistance. Consistent payments of school fees by the authorities responsible are essential, to avoid arrears on the orphans' accounts.

For the proposed recommendations, one should keep in mind that identifying certain programmes is one thing but implementation to fruition and realisation of their full potential is another, as pointed out by Ayieko (2005). Monitoring in terms of performance and potential is therefore essential. Community partnership is necessary; for example, involving caregivers and orphans in the implementation and development of the programmes would generate better results than designing one in isolation and handing it over to them. Involvement of community leaders during planning and implementation is a key factor as well. However, a problem might arise because the participants complained that involvement of community leaders is usually associated with nepotism, leading to a mischannelling of resources; hence implementation will not be that easy in such instances where there is a lack of trust among the community members. At the same time, excluding them would create a sense of isolation and not belonging.

#### **5.4 LIMITATIONS OF THE STUDY AND RECOMMENDATIONS FOR FURTHER RESEARCH**

One of the limitations of this study is that the sample of participants selected comprised grandmothers from just one district. HIV-affected families living in rural areas may not be representative of such families in the rest of the country. A larger sample size, selected

randomly from more than one village in a similar situation, would have allowed for more generalisable results. It should be noted, however, that this was due to the sensitive nature of the topic. Also, the relatively small sample in this study provided a convenient way of conducting the research, taking limited finances and transport problems owing to the socio-economic status in the country into account. Considering that it takes time to build trust with participants, it would have been difficult for me to achieve this quickly if I had selected a rather bigger sample.

The study has engendered a certain understanding of how grandmother-caregivers experience the daily challenges they encounter in the care of orphans. It also brought to light some insights into a few interventions to assist caregivers. However, it did not consider the hardships encountered by male caregivers who are in the same situation. The presence of one researcher may be criticised as lacking objectivity, leading to bias in data gathering and interpretation. It is suggested that a relatively larger sample size, including male caregivers, be used in future studies, covering a wider geographical area with respect to this group of emerging caregivers since it is swelling each day.

As Poindexter and Linsk (1998) note, the strengths of the current study also include the fact that it offered members of a hidden and traumatised population a chance to tell their stories, and the open-ended nature of the inquiry allowed for data that is illustrative and rich. Thus these later-life caregivers were able to make use of the opportunity that the research interview afforded them to bear witness to their dedication to the care of their infected ones and orphaned grandchildren. Therefore, future research should concentrate on literature about grandparents as caregivers and include information on how the HIV epidemic affects older caregivers as well, most importantly the idea that they are a population facing potential health risks.

## **5.5 REFLECTIONS ON MY RESEARCH JOURNEY**

When I undertook the decision to conduct an investigation on the psychosocial impact on rural grandmothers caring for their orphaned grandchildren, I underestimated the

challenges I was going to encounter. Choosing my topic of investigation was a result of the sudden encroachment of the disease on my extended family. Consequently, with the help of a colleague, I arrived at the topic as I had felt the heavy presence of this disease and its deadly impacts on the very old population of my community. Since HIV/AIDS is a sensitive topic in the rural communities, to open the issue to gatekeepers, seeking their permission and assistance, was not an easy road for me. They were sceptical about the reactions of the caregivers, given that their households had not gone public. However, after I had convinced them that my research was purely for academic reasons, they agreed to assist me.

I must admit that interacting with grandmother-caregivers as they related their sad stories was the hardest part of my journey. I discovered that their wounds were still fresh and my interviewing them was more like a prickle, leading to more bleeding. This was manifested in the way they wept during the interviews. Some of the narrations were so sad that I broke into tears as well. They sang songs laden with meaning as they mourned their sad losses, and fortunately enough, I knew some of the songs. Singing together with them brought some relief to the tense atmosphere. In the end, I carried out a double duty: that of a researcher as well as a comforter. On one hand, I was concerned about gathering as much rich data as possible, while on the other hand I had to try hard not to traumatise them with my research.

I recognised that discussing deep details of their late children's illnesses and subsequent deaths was a topic rarely touched on by most grandmothers. They were used to scratching on the surface when talking about the issue. Consequently, probing them to provide finer details made me feel uncomfortable in the beginning but the participants' uncompromising nature actually made me realise how much they valued my research. From my observations, the caregivers seemed not to have spoken so deeply about their situation to other people, because they seemed socially withdrawn.

I was surprised by the kind of welcome I received upon my arrival for the interviews. For most of the interviewees, I was a ray of hope and it was a pleasure to have me listen to



their sad stories. They believed one day I would expose their plight, thus leading to their being assisted. Among the Shona people, visitors are treated in a special manner. Some grandmothers offered me little parcels from their fields: for example, pumpkins, groundnuts and sweet potatoes. I was overwhelmed by their kind nature despite their poverty-stricken households. It was because of this and the realisation of their plight that I went out of my way and bought washing soap and sugar which I presented to them after the interviews. They were more than grateful regardless of the small quantities. Their gratitude was overwhelming and grandma Mugo's remark illustrated how difficult their situation was: *'My daughter, this is the first present ever to touch my hands since the deaths of my children, may God bless you.'*

I must acknowledge that the socio-economic situation in Zimbabwe negatively impacted on my investigation. This was manifested in the way certain gatekeepers mistook my study for a type of charity work. This actually disrupted the selection of participants from one village since the village headman decided to call for a group discussion of all grandmother-caregivers instead of the three I requested. He saw it as inappropriate to have just three when the number was overwhelmingly large. I also encountered problems regarding the same issue of participant selection because in two different villages I was asked to include male caregivers as well. This was a hard time for me, as I was only focussing on women. I felt bad leaving them behind since they were old and fulfilling the caregiving role with no wives to assist them. One of the grandfathers actually showed me his infected grandson, as a way of convincing me to include him in the selection process. Explaining to them why they were not included was a demanding task. This was one unanticipated result of this research as I observed that the epidemic has major implications for family patterns and resources for childcare.

Despite the hardships and the sad stories, I must appreciate that interacting with grandmother-caregivers opened new insights in my way of thinking. Not only do they require physical support, but they also need psychological and social support to avoid alienation and enable successful coping since they are committed to their role. The least

that can be offered is an attempt to identify and support these isolated elders as they face the illnesses and deaths of their children and care for orphaned grandchildren

## **5.6 CHAPTER SUMMARY**

This chapter provided a summary of observations and a discussion of the limitations of the investigation and suggestions for future research, as well as recommendations for intervention strategies, and concluded with a reflection of my research journey. This investigation has afforded some understanding of which grandmothers experience their role as caregivers to orphaned grandchildren. It also brought to light some insight into a few interventions to assist the grandmothers. Based on the findings, it is clear that many elderly grandmothers have lost the support of their adult children who died of AIDS, and they are frequently obliged to deal with the added burden of orphaned grandchildren. Such a shift in the style of parenthood has adverse effects on their late adulthood hope of being looked after by their adult children. This inevitably leads to despair, even among those grandmothers whose lives had been rosy before, as thoughts of loss become overwhelming for them. This could best be summarised by one grandmother's remark that, *'My child, our cultural expectations are shattered, the natural order is that the young ones must bury us, not to die before us, no, this is traumatic'*.

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## APPENDICES

### APPENDIX A

#### INFORMED CONSENT FORM

Title of the research: **The psychosocial impact on rural grandmothers caring for their grandchildren orphaned by HIV/AIDS.**

Researcher's name: Doreen Mudavanhu

Reference number: 35932899

Researcher's position: Masters student

Department: Psychology

Address: P.O Box 392 UNISA 0003 South Africa

Contact telephone no: 091 2940467 (Zim) +27 73 0304848 or +27 12 3861941

#### IMPORTANT MESSAGE TO PARTICIPANT

Dear Participant

Thank you for participating in this study. Should you at any time during the study, experience an emergency as a result of the study or require any further information regarding the study, you can contact me at any convenient numbers from the provided ones or the above address.

Individual interviews will be conducted with you and will be tape-recorded, photographs will also be taken if you give consent. Tapes will be treated confidentially and will only be accessible to the researcher. If you insist on your name being published, only then will the researcher do so.

You are encouraged to answer questions but you do not need to answer particular questions if you do not wish to and can withdraw at any time from the interview.

The researcher will ensure that all the material remains confidential and is stored safely.

The final report of the study will be made available to those participants who wish to read it.

This is to confirm that I (name)-----

consent to participate in the study. I understand that I can withdraw from the study at any time and that identification in the study will be my own decision.

Signature of participant: -----

Signature of researcher: -----

Date: -----

Thank you for participating in this study.

**APPENDIX B****COUNSELLING SERVICES FORM**

Title of the research: **The psychosocial impact on rural grandmothers caring for their grandchildren orphaned by HIV/AIDS.**

Researcher's name: Doreen Mudavanhu

Reference number: 35932899

Researcher's position: Masters student

Department: Psychology

Address: P.O Box 392 UNISA 0003 South Africa

Contact telephone no: 091 2940467 (Zim), +27 73 0304848 or +27 12 3861941

**TO WHOM IT MAY CONCERN:**

This form serves to seek for your assistance in the above-mentioned research work to be conducted in five villages of Gutu district in fulfilment of the requirements for a Masters degree in Psychology.

As part of the requirements of the research, participants found traumatised by the research and therefore in need of counselling, should be provided with. As a researcher, I take this opportunity to ask for your permission to refer such participants (if any), to your organisation if you offer such services.

If you wish to be published in the final report I will do so, but in the event that you want confidentiality, I again will treat your name in that manner. The final report of the study will be made available to you if you give the indication.

Your co-operation will be greatly appreciated.

This is to confirm that (organisation)----- undertake to offer counselling services to the above-mentioned participants of this study. We understand that our name will only be published following our permission.

Signature of representative: -----

Signature of researcher: -----

Village(s) covered: -----

Date: -----

Thank you for your cooperation.

## APPENDIX C

### INTERVIEW SCHEDULE

#### OPEN-ENDED SEMI-STRUCTURED QUESTIONS

- Where and when were you born; can you tell me about your life?
- Can you give a brief history of the events that led to your role as a caregiver to your grandchildren?
- How do you experience full time grandparenting in relation to your hopes and expectations of old age?
- Can you tell me the challenges you encounter while taking care of your grandchildren?
- How do you deal with these challenges, and do you get any assistance, from whom?
- How do you deal with these challenges? Do you get any assistance, and if so, from whom?
- How does your extended family respond to your problems, how about the community?
- Is spirituality or religious life important to you, if so, in what way?
- When you think of the past and the course life has taken lately, what do you have to say, are you satisfied with your situation?
- Are you getting all the support you need, from whom, and what support do you need that you are not getting?



## APPENDIX D

### A NARRATIVE ACCOUNT OF THREE PARTICIPANTS

Although the 12 participants were briefly introduced, I have decided to include a narrative account of three of the participants' life stories in order to supplement the discussion of themes in chapter 4. These stories were selected at random for inclusion in the dissertation.

#### 4.2.1.1 *Grandma Mugo's story*

Grandma Mugo is a 63-year-old woman who lives with her ailing husband and nine orphaned grandchildren. Eight children were born of their marriage and the family had lived in Bulawayo from 1969 to 1999 following Mr Mugo's retrenchment. Her family has been ravaged by HIV/AIDS but there is still no public disclosure about it. The first case was that of her first born (Penny) who passed away in 1999, leaving behind a sickly husband who has not been in touch with the Mugos since the death of his wife. The couple's three children now stay with grandma Mugo. The second case was that of her second born child (Gina), who passed away on December 25, 2005, followed by his wife in April 2006 during Easter respectively, leaving behind five children. The last pregnancy resulted in twins; one of them passed away while the remaining child is handicapped. All the orphans live with grandma Mugo. Her third born child (Glady) also passed away in 1999, just two months after Penny, leaving behind three children, but the last one is now deceased. Glady never married and her children have different fathers.

Including the fourth born child, all are still alive, but the fourth born child (Vhu) is divorced and is now living with grandma Mugo together with her two children. The fifth one (Matso) is married and has eight children but six of them were conceived out of wedlock, which makes grandma Mugo fear for his HIV status due to his risky kind of behaviour. She consequently takes care of nine orphans. To add to her dilemma, her husband is now an unwell patient with cancer of the bladder and can no longer do

anything except merely to sit and soak himself in urine and blood all day since his bladder is now malfunctioning. The spoilt linen is supposed to be washed by grandma Mugo wearing gloves, yet she does not have enough money to keep up with the demand. She even showed me some of the linen that was on the line.

Despite all this, she has been strong enough to travel around the country simply establishing her husband's diagnosis, let alone a cure, but in vain. Owing to all this, she used her livestock to raise money for hospitalisation, so that the family is now in deep poverty, with Mr Mugo's condition deteriorating as the days drag by. Her plight is further worsened by the idea that she cannot obtain external assistance. Noteworthy is her narration of how she surprisingly found her family name omitted from the CARE roll (an NGO that assists needy people with food in rural areas). To add to her stress, she was given no explanation for the cancellation and suspects some foul play among village authorities as there have been allegations of nepotism regarding name enlisting when it comes to external assistance.

One major problem she is facing is that of school fees. Two of the orphans' school fees have been paid by Social Welfare but because of the outstanding arrears, the children were sent away from the school, citing delays in the payment of the fees. Owing to these hardships, she has been persuading one of the orphans who is now in Form Three to drop out of school to lessen her burden but the orphan cries in resistance. Secondary education is expensive and there are four of them in secondary school; hence she is experiencing difficulty in raising the money. Other basic necessities lacking are clothes, blankets, and food. She thus resorts to selling fruits from her small orchard to raise the money, but the problem is that fruits are seasonal thereby not being a reliable source of income. During the time of the research, she had avocado pears for sale.

The other worrying issue troubling her soul is that of acclimatising the orphans to the rural environment. She remarks that some of the orphans could not sleep on the floor and could not do without warm clothes. They too were used to regular check-ups by their family doctors in town. As if that was not enough, the orphans were not used to the

notion of sharing a plate during meals. She however cannot afford to give them each a plate, as she does not possess enough. Given all this, her heart is troubled every time the orphans come back from school, wishing their parents were alive to fend for them. Grandma Mugo is alone in her burden of care since her husband cannot assist her but rather adds to her predicament. Anticipatory grief grips her as she watches her husband deteriorating daily. She cried during the interview as she pleaded with God to heal her husband.

In great distress, she finds comfort in prayer, as she can no longer rely on her ailing husband. She asks God to grant her husband more days on earth so they can fend for the orphans together. She has turned out into a socially withdrawn person as she no longer leaves her home, even to attend funerals in the village, since the state of her husband does not warrant his being left unattended to. Due to these hardships, grandma Mugo has developed back pain; she cannot describe how it came about, but just prays to God to make her strong lest she be hospitalised and cripple the whole family. One should note that grandma Mugo spend the greater part of the interview in tears: even upon arrival, she welcomed me, struggling to stop tears from falling. This made me uncomfortable as I felt that I was causing emotional pain to her.

#### **4.4.2 Grandma Rati's story**

Grandma Rati has nostalgic memories of her early years of marriage before her husband married a second wife. She cannot recall when she was born; neither could she locate her identity document. However, she seems to be in her late sixties. Although the years when her children passed away are attached to certain events, some she cannot even recall. She bore six children from her marriage and they used to live in Harare as a family. The first-born child, Gari, passed away having divorced his wife: they had one child and the wife's whereabouts are not known. The second born child (Tafa) died in 2004, leaving behind a wife and two children. The wife thereafter dumped them, including a suckling infant in the care of grandma Rati; the child is now turning three and has been under her care since then. The third son, Mazvi passed away in June 2005, leaving behind his wife and a child.

The wife remained in Harare while she sent her ailing husband home to be cared for by his mother as his situation was critical. She has not contacted grandma Rati since. Her fourth born son, Bothie, is said to be married and living in Harare but she has not heard from him for years. The fifth born child is a girl, Monica, whose husband died; their only child now lives with grandma Rati. Her last-born is still single and has completed his 'O' Levels.

Grandma Rati thus cares for three orphans and at the time of the interview, she had just recovered from severe illness, as she is a Tuberculosis patient. She recalls how her husband married a second wife and abandoned her in the rural area with nothing, leaving her children in Harare except for the last-born. According to the traditional Shona practice, her parents could not receive her back without formal notification by her husband's family. Hence they urged her to stay and endure the hardships. Since that time, she has been living a life of supplying labour in the community in exchange for food or cash to send her child to school. Up to the time of the interview, she has been doing the same to fend for the orphans.

Her problem is that of her ailing body as she suffers from TB. She has also suffered from Herpes, which left her hearing partially impaired, and this adversely affected the interview process. Due to these illnesses, her capacity to keep on working for the orphans in exchange for food or cash has been grossly affected, yet she has nowhere to turn to. Her plight was worsened when her ailing husband with his second wife returned to the rural areas to be cared for by her, and subsequently died, leaving behind a sickly child who was believed to be infected from birth. The child later passed away at about seven or eight years and had been under grandma Rati's care since infancy. She toiled over the child all the days of his life since he was in and out of hospital.

She is worried about the future of the orphans. She struggles to feed them and does not possess soap to wash and clean the children, let alone their clothes and blankets. She is however indebted to BEAM for assisting her with school fees regarding one of the orphans who is in grade three. Yet she complains that books are expensive and

consequently her struggle continues. Her problems become so burdensome that she at times cries but later consoles herself that she is not the only one in this situation. Her coping strategy is through prayer and she asks God to grant the orphans more life. She ponders a lot about her deceased children but accepts that she cannot do anything about it, as they will never come back. Thus, when in great distress, she notifies her young sister who then brings whatever she can find for the orphans and comforts her for the few days she will be visiting.

#### **4.4.3 Grandma Ruva's Story**

Grandma Ruva is an elderly looking woman of 76 years, yet she is the breadwinner of the family. She bore eight children from a polygamous marriage, being the third and youngest wife. She lost a son and a daughter in-law to AIDS. Her son, whose wife passed away, is ailing and now under her care, since he could not continue working as a driver in Masvingo town. He has three children with his late wife. The youngest is turning four while her mother died when she was only a week old. Now grandma Ruva is caring for the three orphans, along with their father. She also cares for one other orphan (her daughter's son) following the death of her son in-law. The orphan's mother is now staying with grandma Ruva, as well as her older sister, who is a divorcee. Neither work and both depend on grandma Ruva.

Grandma Ruva's husband passed away (year not remembered) after being paralysed for the last ten years of his life, and had been cared for by her, since the other wives had passed away previously. She now cares for four orphans with no form of assistance and a sickly son on the other hand. What worries her is her decreasing ability to work as she solely depends on farming for survival. Her body is now being troubled by aches and she is worried about the future of the orphans. Her son cannot do anything, as he is bed-ridden. She has not received any community or familial support and therefore fights a lone battle. She pays school fees for three orphans and is struggling to raise the money. She reiterates that hers is a difficult job, especially in confronting the status of her ailing son, which consequently sinks her into anticipatory grief as his situation deteriorates with

the passage of time. To make matters worse, she does not possess livestock to sell and raise money for his medication; thus only time will tell if his condition will improve.

The death of her daughter in-law adversely affected her spiritual well being, as she has lost faith in going to church. She confesses that she cannot afford to face the usual place where her daughter in-law used to occupy in church yet she is gone forever. She still grieves for her and this is worsened by the idea that she left a week old baby who has since been under her care. Owing to the economic hardships gripping the country, her other children cannot assist her since they are involved with their families. The help she desires most is that of school fees. She emphasises that re-parenting is a taxing job, because she has to go down to the river, bath the orphans, as well as doing the laundry. Washing soap, clothes and blankets are problematic as well. She worries a lot about her poverty-stricken nature and wonders if it will come to an end. Her future appears bleak when she thinks of her ailing son, since she cannot do anything to improve his situation and she fears another imminent loss, having experienced others before. Her situation would have been better if she had someone to share her problems with but she has no one to turn to even in times of great distress. She shows no knowledge of the HIV/AIDS disease but rather calls it *the disease* that is only there to take away her children.